State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Reg. No. UUD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vaar **Physician** Yvonne B. McGee 02:15 AM 28, 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE, MD. ST. AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 💢 F Months Days 53 Yrs. Director 218-60-6750 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic avant, the Modical Examinar must be notified at n/a 1 Yes 2 No Directo Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1331 Pentridge Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes You If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married African-1 ☐ Yes 2 No Specify: β 3 ☐ Widowed 4 ☐ Pivorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Johns Hopkins Elementary/Secondary (0-12) Lab Tech Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F is marked of Bernard Booker Catherine Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Item 27 is Tonya N. Thomas/Daughter 2921 Pumpkin Street, Clinton Md., 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: if Iter
any injury or oth 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 6/3/06 Woodlawn, Md 21. Signat of Funeral rvice Licensee 22. Name and Address of Facility Wylie F/H PA of BaltimoreCo 9200 Liberty kd., Randa 23 First. Enter the diserve, or o-mplicity is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. 9200 Liberty Rd., Randallstown, MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLITUS DIABETES 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? performed? STAGE RENAL DISEASE END 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury al Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation Hospital or Attand 24 hours after death Funerel Diractor; 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours an To the Funerel D 1 Cartifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and his her as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AWAIS MASOOD P-19508 , MD. MAY 28,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWAIS MASOOD, MD, ST. AGNES HOSPITAL, BALTIMORE MD 21229 31. Date filed (Month, Day, Year) 32. Signature State Registrar MAY 3 1 2006

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			State Registrar		Ce	rtificate	of Death		eg. No.	0 17004				
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	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Ext	aminer: On the basis of e and manner state	xamination and/or	investigation,	in my opinion, death occ	curred at the time,	date and place, and	I due to the cause(s)				
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	r 28a	rec	10e. Street and Number				10	f. Zip Code				10g. Cit	0g. Citizen of What Country?		
	th with	al D	3805 Mary Ave	nue				21206				U.S.	Α.		
	er dea	Funeral Director	11. Marital Status	Armed		r in U.S.	13. Was I If Yes	Decedent of H specify Cuba	ispanic Or ın, Mexicai	igin? (Spe n. Puerto l	cify Yes or N Rican, etc.)	lo-	14. Race Black	- Americ , White,	
39	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Iteme 23a or 28a-f ehow ant, the Modical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Ma 3 🔀 Widowed 4 ☐ Divorce	d li Yes, 0	2 □ No Sive Dates: 19	35-38	1 🗆 Y	es 2⊠ No	Specify:	:			Specify:	Wh	ite
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any injury or other traumatic evant, the Modeal Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (1		, cremator	or other place emetery			ate 2,2006		altim		
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	1		30. Name and address of perso	n who completed ca	use of death	h (Item 23a) (Type Print	ive	Je Z	716	Peri	yfi	10/1	m	2/128
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ORIGINAL

			1 - State Registrar Amend #73a Per	State of Marylan					ene 0	06	17004	
			1. Decedent's Name (First, Middle, Last)	Hny G556 6/16/U) JH			2. Date of Death	1		3. Time of Death	
	Physicia		Michael Jos	eph McCov				Month	Day	2006	07:05AM	
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. Count	y of Death		
	Examili	eı	Union Memori	al Hospital		Balt	imore					
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vaarl	9. Birth	year 2006 of Death 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No What Country? 9. American Indian. 10k, White, etc. White usiness/Industry Orary Service 10. State, Zip Code) 20. Amd 21157 City or Town, State 11e, MD 21228 Approximate Interval Between Onset and Death 30 years 30 years 30 years 10. Ambute to the cause of death? 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Ner (Specify) Ted Ter or Rural Route Number, Tanner as stated.	
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	deeth with the Maryland me 23s or 28s-f ehow Frount be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Cou	ntry?	
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	1 and 2 Health tem 27 l		Kathryn M. Winder	Sister	_		*	minster,	, Mary	1and	21157	
Baltimore,	of Healt item 2 r other		20a. Method of Disposition	20b. F	Place of Dispo cometery, crea	osition (Name of matory or other place	9) 05/27		0c. Location	- City or To	own, State	
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	Dhamisian		shock, or heart failure. List only or tmmediate Cause (Fina	re cause on each line.	1	₩ Hyperten	_				Onset and Death	
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ပ္ရွိ	has be	ple						24a. Was an autopsy	/	prior to co	opsy findings available empletion of cause of	
r	The ete h page	Completed						perform	led? ☑No	death?	2 🗆 No	
<u>=</u>	iclan: Th certificete rector, pag	BeC	25. Was case referred to medical				26. Place of Deat	h (Check only one	9)		•	
_	Attending Physician: It death. ector; After this certific by the funeral director.	To E	examiner? 1 ☐ Yes 2 ☑ No	lospitat: 1 ☐Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Resider	nce 6 🗆 O	ther (Specia	fy)	
0	ng Pt ter th	Ë	27. Menne of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe hor				
<u></u>	ath. r: Afr	atio	1 Matural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(a.)		Yes 2 □ No					
Division of Vital Records,	Atte ecto by th	iii	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h		reet, factory, office		28f. Location (Str. City or Town,		ber or Rur	al Route Number,	
ā	elor s efte i Dir	Certification;	4 - Hornicide	building, etc. (Special	ry/			City or Town,	, 5,410/			
	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director; After this certificete ha completely filled in by the funeral director, page			sician: To the best of my kno								
	Ho Fu e Fu letely	Medical		ner: On the basis of examina and manner stated.								
	ro th vithin ompl	Me	29b. Signature and title of certifier	up Ti		29c. Licenso	number	29	d. Date sign	ed (Month,	Day, Year)	
	- > F 0			M. C		AT 74	138946		Hans	25. 20	006	
•	\cap		20 Name and address of access when				100710		, , , , ,	1		
	1		30. Name and address of person who co WALID BARBOUR,			ial Hospita	L MD					
die	0.		31. Date filed (Month. Dav. Year)	140			1 / 1 1 2.00					
	Sta Regist	ate i rar	31. Date filed (Month, Day, Year) MAY 3 I 2006	Hegistrans Signa	1 Am	de						
	gist		- La00	Marie 10	Petro	in the second						

DHMH 17 Rev 1/2001

ORIGINAL

			for State	State of Mar	yland / De	partmer	nt of Health a		-	-	17005	
			Registrer	.1		eruncai	te of Death		Reg. N	of UUb	600/1	
	Physici	an	1. Decedent's Name (First, Middle, La Arliss Ju	ne Mayo					Date of Death Month	Year Zoc		
	/Medic Examin		4a. Facility Name (If not institution, gir	2		4b. City.	Town, or Location of	f Death		c. County of De		
	LAGIIII) 	()	sital of t	Baltimo				tu	N,		
	Funeral Director		5. Social Security Number 6. 502–58–1382		In yrs. last birthd 55 Yrs	ay) If Unde	r 1 Year If Under 2	24 Hrs. 8. 1 Min. 1,	Date of Birth (Month, Day, Yea / 22/51	r) 9. Bi	rthplace (State or Foreign country)	
-	and		Usual Residence of Decedent 10a. State 10b. County		I Oc. City, Town or	r Location					101 1-11 01 11-11	
	death with the Maryland ms 23s or 28s-f show	Funeral Director	MIN	Polk			East Gra	nd For	cks	10d. Inside City Limits 1 [XYes 2] No		
	with 1	Dir	10e. Street and Number 121 Jupiter Drive	7		10f. Zip	Code 56	271	10g. C	itizen of What C	·	
	death ms 20	nera	11. Marital Status	12. Was Decedent Ev	er in U.S. 1	3. Was Dece			Yes or No-	US 14. Race - Am		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exanter institute to collicit	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2XX0 o If Yes, Give Year or Dates:		If Yes, spe	dent of Hispanic Orig cify Cuban, Mexican, 2500 Specify:	Puerto Rica	n, etc.)	Black, White, etc. Specify: White		
) A (within 72 ho ene. then "netu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(G	ive kind of wo e. DO NOT u	al Occupation ork done during most se retired)	of working	16b. Kind of Business/Industry			
7 2	filed w Hygier Ither th	Cor	12	0		Chef				Restaura	nt	
i55 Maryland	be fill hall Hall Hall Hall Hall Hall Hall Ha	Be	17. Father's Name (First, Middle, Last Arthur Howard A				1		st, Middle, Maide	/		
2 Z	should nd Mer marke	Lo	19a. Informant's Name/Relationship		105.14	-10 4-4			lendora	_		
. 5. Ba	nd 2 s Ilth an 27 is r r traus		Mary Thomas / S				er Dr., Ea				Zip Code) 6721	
R.L.	s 1 and Heal item (20a. Method of Disposition	-	20b. Place of Dis	sposition (Na	me of	Date		ocation - City or		
A P	Pages nent of int: If it iry or o		t ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Middle	Grove	Cem. May	30, 20	06	rand Fo	rks ND	
ARLBaltimore,	permit. Departn Imports any inju		21. Signature of Furieral Service Lice	nsee		22. Name ar	nd Address of Facility les L. Steve Fast Fort A	ens Fune	eral Home	Inc.		
	200		23a. Part 1. Enter the disease, or dom shock, or heart failure. List only	nplications that caused the	e death. Do not	enter the mod	le of dying, such as co	ardiac or res	spiratory arrest,	21,230	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	. A cute		O Cari	1 [Force	timo		Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a c		, arr	1	1 400	uor		10 hours	
	-	_	Sequentially list conditions,	b. Ather	OSCLEVE	olic	heart	d	Slase		10 years	
100	uted J anslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Apriti	e +	0050					-	
,	te be executed ysicien and le burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):	no n'	<u> </u>				3 years	
1760,	2 2 0	cai	(_ d							_	
68	artifica ing ph a as th	Med	IF FEMALE:									
Division of Vital Records, P.O. Box	that the death certifica ed by the ettending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2 (4☐Pregnant at tin	Fetal death	3 ⊟Ectopic pi 5 ⊟ Other (sp				23d. Date of de Month	livery Day Year	
0.0	at the by the stache	hys	9 ☐ Unknown	9□ Unknown			·					
s,	res tha igned be de	by	Part II. Dther significant conditions		not resulting in the	underlying c	ause given in Part I.		23e. Did tobacco	use contribute to	the cause of death?	
ord	w requir been si should	Completed	Longistive	nlar	tan	lure			1 Yes 2	.□No 3□P	robably 4 Unknown	
Sec	e law has b	npie							24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
<u></u>	icien: The l certificate ha ector, page								performed? 1 ☐ Yes 2 ☐ No	death?		
Vit.	sicien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Other		eck only one)			
of	Phys or this aral di	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient	2 ER/Outpat				5 Residence Describe how inju		cify)	
ion	nding F ath. r: After e funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Y	ear) Injur	м	8c. Injury at Work? 1 ☐ Yes 2 ☐ No		Describe now inju	ny occurred		
Vis	r Attendi er death. rsctor: A by the fu	tifica	3 Suicide 6 Could not b		- At home, farm,	street, factory	r, office	28f. L	ocation (Street a	nd Number or Ri	ural Route Number,	
Õ	itel or ref Dir led in	Cer			,				City or Town, Stat	•		
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certification;	29a. Certifier 1 → Certifying Ph (Check only one) 2 ☐ Medical Exam	nysician: To the best of r miner: On the basis of ex and manner stated	annination and/or	ath occurred investigation	at the time, date and in my opinion, death	place, and d occurred at	lue to the cause(s the time, date an	and manner as d place, and due	s stated. to the cause(s)	
	To To com	2	29b. Signature and title of certifier	. / 5 . 1 f			. License number		29d. Da	ate signed (Mont	h, Day, Year)	
	DN.		Lugenie	W. Match	wender	Mh	RES - (000	~	lay	21,2006	
"			30. Name and address of person who	completed cause of deat	th (Item 23a) (Typ	e, Print)	C:	ı L	. 1	1 5	214-	
is	Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's	Signature	7 (11)) Din	au r	rospita	1 of	pallimore	
16.	Registr	1.7	MAY 3 1 200	Mark.	J. A	242			4	•		

		1	FOI	artment of Health and Menta ertificate of Death	I Hygiene	17006			
	Dhyninia	_	Decedent's Name (First, Middle, Last)	Mor	e of Death oth Day Yeer	3. Time of Death			
	Physicia /Medic	al	WITHEY MULLINS	4b. City, Town, or Location of Death	4c. County of Dea	2			
	Examin	er '	4a. Facility Name (If not institution, give street and number) Millenium Nursing Home	Ellicott City	Howard				
Ī	Funeral Director		5. Social Security Number $\begin{array}{cccccccccccccccccccccccccccccccccccc$		e of Birth nth, Day, Year) e 27, 1940	thplace (State or Foreign (State or Foreign			
	pu »	—	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits			
	Aaryla f shov		MD Howard	Ellicott City		1 □Yes 2√ No			
	28a-	rect	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Citizen of What Country?			
	th with	a D	3000 N. Ridge Road	21042		SA			
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☐ No Specify:	s or No- etc.) 14. Race - Am Black, Whi Specify:				
21215-0036	thour	ed b	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business	/Industry			
215	hin 72 9. Ban "ne	plet	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)					
7	ygien ygien her th	Con	12	Disabled 18 Mother's Name (First	N/A				
and	ntal Hed otl	ă	17. Father's Name (First, Middle, Last) Joseph Benjamin Overton	· ·	s Name (First, Middle, Maiden Sumame) Ira Marie Stevenson				
Maryland	shoulk nd Me s mark umatik	ဥ		ling Address (Street and Number or Rural Route	Number, City or Town, State,	Zip Code)			
Ĭ,	s 1 and 2 of Health ar item 27 is other trau			B Crestleigh Court Fin					
ore	ges 1 and He If item or oth			ematory or other place)	20c. Location - City of				
Baltimore,	rtment rtant: njury		+ Bonanon + Berner (epenny)	vn Mem. Gardens 5/31/0					
Bal	Depar Impo		Dune Cather	22. Name and Address of Facility HAIGHT FUNERAL HOME & Sykesville, MD 21784 (410)-/95-1400	1			
			23a. Part1. Enter the disease, or complications that paused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respir	atory arrest,	Approximate Interval Between Onset and Death			
ł	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	toge					
	Examiner		SERCIC						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	- 1 0 =					
1/0	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	FAILURE					
8760,	be ex	Ilcal E							
9	ificate g phys as the	edlo	u.						
P.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy ☐ Other (specify)	23d. Date of de Month	blivery Day Year			
	w requires that s been signed b s should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	te. Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ F	robably 4 Junknown			
of Vital Records,	aw req is beer 2 shou	Completed		24	a. Was an 24b. Were a autopsy prior to	utopsy findings available completion of cause of			
Re	a ~ 6	omo		10	performed? death?				
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ck only one)					
of \	Phys this al dii	2	1 Tyes 2 To Hospital: 1 Inpatient 2 ER/Outpat 27. Manger of Death 28a. Date of Injury 28b. Time	☐ Residence 6 ☐ Other (Sp. escribe how injury occurred	ecify)				
uo	ing After une	tlon	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		, ,				
Division	5. 5. te o	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Lo.	cation <i>(Street and Number or F</i> ly or Town, State)	Rural Route Number,			
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and durinvestigation, in my opinion, death occurred at the	e to the cause(s) and manner and time, date and place, and du	is stated. le to the cause(s)			
)	To th withir To th	Me	29b. Signature and title of certifier	29c. License number D 5-3 9 8 7	29d. Date signed (Mor	nth, Day, Year)			
•	2		30. Name and address of person who completed cause of death (Item 23a) (Type 200)	e, Print) KENNETH C	TEN MD	1.			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 3 1 2006 33 Registrar's Signature	nade					

			FOR	epartment of Health and N Certificate of Death	Re	g. No.	17007					
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Alice Loretta Mursch		2. Date of Death Month May	28, 2006°	3. Time of Death 12:25 pm					
	Examin		4a. Facility Name (If not institution, give street and number) Continuum Care	4b. City, Town, or Location of Death Sykesville	1	4c. County of Death Carrol						
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 90 Yr	Months Days Hours Min.	8. Date of Birth (Month, Day, May 8,	Year) 9. Birthp Cour 1916 N	place (State or Foreign http) Y					
	show	_	Usual Residence of Decedent	r Location Randallstown		1	10d. Inside City Limits 1 ☐ Yes 2 X No					
	ith the Marylar or 28a-1 show se notified at	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinat must be notified at 2008.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	21133 13. Was Decedent of Hispanic Origin? (Simple of the Market of Hispanic Origin?) 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race - Americ Black, White, Specify: Wh	can Indian,					
Maryland 21215-0036	ithin 72 hounne. ne. han "natural" y Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	king	6b. Kind of Business/Ind						
and 21	d be filed water Hygier the other the sevent, Ital	Be	17. Father's Name (First, Middle, Last) Eugene Burke	Homemaker 18. Mother's Nan Mary	ne (First, Middle, N	Domesti Maiden Sumame)	C					
Maryl	nd 2 should lth and Me 27 Is mark traumation	70	19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and Number or Ru			Code)					
Baltimore,	Pages 1 ar ent of Hea nt: If Item ry or other		Mrs. Alice Carichner (Daughter) 6405 Hickory Lane, Sykesville, MD 21784 20a. Method of Disposition 1									
Balti	permit. Departm Importa any inju		Duan A. Hayes	HAIGHI FUNERAL HOME Sykesville, MD 217	784 (410)	-795-1400	195)					
8760, A	Cate be executed /Medical Examiner bhysician and sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or complications that dassed the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions of t	St,	Approximate Interval Between Onset and Death							
P.O. Box 6	Physician: The law requires that the death certific t this certificate has been signed by the attending pr ral director, page 2 should be detached for use as	Physician/Me										
	uires that the de signed by the Id be detached	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		acco use contribute to the						
I Recor	The law requira ate has been si page 2 should I	Completed			24a. Was ar autops perform 1 Yes 2	prior to co death?	opsy findings available impletion of cause of					
Division of Vital Records,	ing Afte une	To Be	25. Was case referred to medical examiner? 1 Yes 2 \ D \ Hospital: 1 Inpatient 2 ER/Outp 27. Manner of Death 1 Natural 5 Pending	atient 3 DOA Other: 4 Nursing H	ath (Check only one dome 5 Reside 28d. Describe ho	nce 6 Other (Specif	(y)					
Divisi	_ 0 E _	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Str City or Town	reet and Number or Rura , State)	al Route Number,					
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Gertifying Physician: To the best of my knowledge, on the basis of examination and and manner stated.									
	•	M	29b. Signature and title of certifier CONCE M	29c. License number D-00542 ype, Print) Malca(malu	218 (3d. Date signed (Month,	Day, Year)					
	<u></u>		30 Name and a less of person who completed cause of death (Item 23a) (TDR - Kanus, 3	ype, Print) Malcalin du	y nest	minsty MD	21157					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registrar's Signature	ale								

			1 - For State Registrar	State of Maryland / De	epartment of Health Certificate of Deatl	h	ene g. No. 2006	17008				
ı	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
	/Medic	cal	Ernestine New		4b. City, Town, or Location		4c. County of Dea	9:55 AM				
<i>*</i>	Examir Funeral Director	ner	Sinai Hospital OF 5. Social Security Number 6. Sex	Baltimore	Baltimore day) If Under 1 Year If Under Months Days Hours	city er 24 Hrs. 8. Date of Birth		thplace (State or Foreign ountry)				
	D D		Usual Residence of Decedent	100 City Town		04 22						
	Marylar (show	ō	10a. State 10b. County N/A	10c. City, Town of BaH	timone			10d. Inside City Limits 1 > 2 □ No				
	death with the Maryland irra 23a or 28a-f show ir must be notified at	Funeral Director	10e. Street and Number 3711 W. Belver	tere Avenue	10f. Zip Code 2121		g. Citizen of What Co	ountry?				
250	hin 72 hours after death with the Marylan e. an "natural", or itema 23a or 28a-f show Medical Examinat must ke notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specif	an, Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify:					
2-0030	72 hou	eted	15. Decedent's Educ (Specify only highest grade	completed) ((ecedent's Usual Occupation Give kind of work done during me	ost of working	6b. Kind of Business					
7	≥ 2 3 ≤	Completed	Elementary/Secondary (0-12)	College (1.4er Ex)	ite. DO NOT use retired) viatric numi	na assistant	Rosewood					
מש	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)			her's Name (First, Middle, Ma						
ryian	ould Men Merke Merke Merke Merke	2	Hezekiah Nev	vsme	Mailing Address (Street and Num	lier Jones	City or Town State	Zin Code)				
<u>8</u>	and 2 sh lealth and m 27 is m		Sherie K. Baker	Marin Color 1000019	711 W. Belveden		to. MD 2	1215				
gaitimore,			20a. Method of Disposition 1	emoval from State	Disposition (Name of crematory or other place)		Oc. Location - City or					
E	그 문문을 .		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		lembrial Park	05.30.06 K	Landailsto	UNINID				
ä	Depa Impo any li		I ken W.	São	22. Name and Address of Fac Unughn C. Gree 4903 York Koa	ne runual sei d Baltimore	MD 21212	_				
ı			23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	e cause on each line.	t enter the mode of dying, such a	as cardiac or respiratory arres		Approximate Interval Between Onset and Death				
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Tutracranial N	nemorrhagic v	netastasis						
	Examiner		Sequentially list conditions,	Lung Cancer	<i>y</i> .			6 weeks				
	Pa 35	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence of):							
Ň	execut in and ial-tran	Examin	that initiated events cresulting in death) Last	Due to (or as a consequence of):							
8/60,	cate be executed physicien and the burial-transit	dical	L.	1								
O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year							
rds, P	The law requires thet the tte bas been signed by the bage 2 should be deteche	þ	Part II. Other significant conditions cor Diabetco, Hypert	ntributing to death but not resulting in t		1		the cause of death?				
Vital Hecords,		Completed					ed? prior to death? Yo 1 ☐ Yes	utopsy findings available completion of cause of				
	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 ER/Outp	l ou	ce of Death <i> Check only one</i> Nursing Home 5 Residen	·	ocity)				
on of	ding Phy h. After thi funeral		27. Manner of Death 1 Satural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tir	ne of 28c. Injury at	28d. Describe how						
DIVISION	el or Attends after deatl	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)			eet and Number or R State)	ural Route Number,				
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kin whole death occurred at the time, date and place, and due to the cause(s) and manner stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	Vith with	2	• Euler & May 23, 2006									
	5		30. Name and address of person who co	ompleted cause of death (Item 23a) (T 1 Simai Hospital	of Baltimore		<u> </u>					
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature								
	, regist	rell	MAY 3 1 2006	Allabora 18 lin	24/19							

			State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 7009											
п	Physicia	an	1. Decedent's Name (First, Middle, La: WAYNE	st)	NOCAR	Tī				2. Date of Dea Month	Day 26	Year	3. Time of Death \$:30 PM	
	/Medic		4a. Facility Name (If not institution, give	e street and nu			4b. City, Tox	vn, or Loca	tion of Deat			2006 unty of Death	0.30	
	E.Xalliili	C1	JOHNS HOPKINS	BAY	VIEW		BAL	TIMOR	E	477				
	Funeral Director		5. Social Security Number 6. S	ex M∑M 2□F	7. Age (In yrs.	last birthday) 26 Yrs.	If Under 1 Y Months D	ear If U		8. Date of Birt (Month, Day December	30 , 1979	9. Birthp Coun Maryl		
	pud A		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					1	Od. Inside City Limits	
	f aho	ō	Maryland Baltimo	re	9	Sparrow	s Poin	t.					1 ☐ Yes 2 X No	
	r 28a	rec	10e. Street and Number				10f. Zip Co				10g. Citizen	of What Cour	itry?	
	th with	aiD	16 Shore Road				2	1219			USA			
336	72 hours after death with the Maryland natural; or itama 23a or 28a-f ahow disal Examiner must be notified at	by Funeral Director	11. Marital Status 1 Marital Status 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2 X No ve		Was Decedent If Yes, specify 1 ☐ Yes 2X		c Origin? (S xican, Puer ecity:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.	
21215-0036	72 hours "natural", citcal Exc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	dent's Usual C kind of work of DO NOT use i	lone durina	most of wo	rking	16b. Kind	of Business/Inc	dustry	
121	within iene. r then	omp	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)		entice	өшгөа)			Heatir	ng & Ai:	g & Air Condition	
Dd 2	be filed ital Hygie d other avant, II	Be C	17. Father's Name (First, Middle, Last)		1				me (First, Middle,	Maiden Sui			
ylar		10 1	Wayne Barry Nocar							Mae Spai				
Maryland	12 ha 7 ls		19a. Informant's Name/Relationship (Deborah M. Claric		other	1				ws Point			Code) 21219	
	es 1 an of Heal of Itam 2 or other		20a. Method of Disposition 1X Purial 2 ☐ Cremation 3 ☐	ion - City or To	wn, State									
Baltimore,	permit. Pag Department Important::i any injury o		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Mome Of 1 t Road, 1	Dunda]	k.P.A.							
			23a. Part1. Enter the disease or com shock, or heart failure List only	plications that	caused the deat							LK, FID.	Approximate	
)	Physician /Medical		shock, or heart failure List only Immediate Cause (Final disease or condition resulting in death)	a	RAIN	HERN				O N	٨		Interval Between Onset and Death	
	Examiner		Due to (or as a consequence of):										1 day	
	₩ #	iner										J		
	hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):			APPRI	MED BY ME				
8760	ate be only sicient the buri	ical	(d				CERTIFIC	ATION					
9	ndifica ng ph as th		IF FEMALE:											
P.O. Box	The law requires that the death certificate be executed as has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live	itcome of pregnibirth 2 Feta nant at time of c nown	al death 3	□Ectopic pregi □ Other (speci				23d	. Date of delive Month	ory Day Year	
	quires that in signed by uld be deta	Ď	Part II. Other significant conditions	contributing to o	death but not res	sulting in the u	inderlying caus	se given in l	Part I.		obacco use Yes 2 🔀 N		ne cause of death? abiy 4 ∐Unknown	
Records,	The law requiete has been page 2 should	Completed										prior to cor death?	psy findings available inpletion of cause of	
Vital		Bec	25. Was case referred to medical examiner?					1 -	Place of De	ath (Check only o				
→	this al di	2	1 X Yes 2□ No	Hospital: 182		ER/Outpatie			☐ Nursing I	Home 5 Resid			y)	
on	ding f th. After funer	tion	27. Manner of Death 1 □ Natural 5 □ Pending 2 ▼ Accident investigation	(Mor	nth, Day Year)	Injury		Injury at Work? 1 ☑ Yes	2 🗆 No				asement.	
Division	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined	28e. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, st		ffice		City or Tov		umber or Rura	BALTIMORE	
	Hospita 24 hours In Funera etely fille	Medicai C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the	e best of my kn	owledge, deal	th occurred at			e, and due to the	cause(s) an	d manner as si	tated.	
	To the within To the compl	Me	29b. Signature and title of certifier				29c. L	icense nun	nber		29d. Date s	igned (Month,	Day, Year)	
			> hom		M.D.			LES-		(u	147)5/	27 ,	2006	
	6		30. Name and address of person who	completed cau	ise of death (Ite 40 EAS	m 23a) (Турв Т <i>Е</i> ГА	Print) AVENU	3, BA	LTIMOR	£ 2122	4			
	Sta		31. Date filed (Month, Day, Year)	32.1	ise of death (Ite HO EAS' Registrar's Sign	ature	1				•			
DI	Regist		MAY 3 1	2000	OF SELECT	15.	10000							

ORIGINAL

		1	For State of Maryla	ind / Department Certificate		ental Hygie	711115	17010					
	23 Kg		1. Decedent's Name (First, Middle, Last)	- Cortinoato	or Bouil	2. Date of Death	140.	3. Time of Death					
п	Physicia		7 11 11 +11			MAY 2	8 2006	10 05-AM					
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City. T	own, or Location of Death		4c. County of Death	1000					
	Examin	er.	1 - 6 - 1 11 - 1		RALTIMORO.		NIA						
				s. last birthday) If Under 1	Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign					
	Funeral Director		714-12-4252 10M 20# 8.	Yrs. Months	Days Hours Min.	(Month, Day, Ye	1921 Cou	ntry) M					
	*	-	Usual Residence of Decedent					7 0 1					
	yland		10a. State 10b. County 10c.	City, Town or Location	*			10d. Inside City Limits					
	Mar Fed	ţo	MD WA	BAL	Timore			1 Yes 2 No					
	r 28g	le e	10e. Street and Number	10f. Zip (Code	10g.	Citizen of What Cou						
	h witi	by Funeral Director	3719 . E. Northern For	KWACZ	21206		U.5.A.	4					
	deat	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decede	ent of Hispanic Origin? (Spe fy Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,						
9	after or its	F	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2			1	oite					
5-0036	72 hours after death with the Maryland netural; or Items 23a or 28a-f show dical Exercitiver instal be notified at	5	3 Widowed 4 Divorced Year or Dates:				Specify (6)	WILL C					
5-	72 h netu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual (Give kind of work	k done during most of worki	ng 16b	. Kind of Business/Ir	ndustry					
21	within ene. then	du	Elementary/Secondary (0-12) College (1,4or 5+)	life. DO NOT use			Home						
21	ygier her ti	S	12Th NA	Home	MAKER	(First, Middle, Maid	,, , ,						
n n	be fi	To Be	17. Father's Name (First, Middle, Last)		a same g		•						
Zla	ould I Meni varke	၉	CHARLES APPELT.	405 Mallian Address	Dophie			n Codol					
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)		(Street and Number or Rura			\sim					
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygene them 23 is marked other than "netural", or items 23 ar 28s-1 show other traumatic event, the Medical Exercitive mant he notified at	ŀ	20a Method of Disposition 20b		STBEND ST		Location - City or T						
Ö			Burial 2 Cremation 3 Removal from State	Place of Disposition (Namcemetery, crematory or off	her place)	į .	20 1.70x						
Baltimore	permit. Page Department of mportant: If eny injury or once.		4 □ Donation 5 □ Other (Specify)	BALTIMORE Da	Tional Cem 12	166	3Alto. M.) •					
39	Deparential Depare		21. Signature of Funeral Service Licensee	PAUL	Address of Facility	RAL HOME	A PH						
	4030d		23a. Park. Enter the disease, or complications that caused the di	7527 h	arpord RO.	130 ITO -14	\$ 21234	Approximate					
			shock, or heart failure. List only one cause on each line.					Interval Between Onset and Death					
	Physician		Immediate Cause (Final disease or condition resulting in death)	2 Cereb	wascule a	deseas	_						
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a										
			Sequentially list conditions, if any, leading to immediate Due to (or as a cons	coscoleric (ardw visu	ela al	2200	9					
L	ted isit	Examiner	Cause (Disease or injury										
4	be executed ician and burial-transit	хаг	that initiated events resulting in death) Last	sequence of):									
760,	ite be ex iysician he burial	calE											
687	ficate phys s the		0.										
×	leath certificat attending phy I for use as th	× W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre-				23d. Date of deliv	/ery					
Box	atter atter	Clar	in the past 12 months? 1 Yes 2 No				Month	Day Year					
o.	law requires that the death certifica as been signed by the attending ph 2 should be delached for use as th	Physician/Med	9 ☐ Unknown 9 ☐ Unknown										
٥.	res that igned b	by P	Part II. Other significant conditions contributing to death but not	resulting in the underlying ca	ause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?					
rds	en sig		Metastati Cance	of Jus	es	1 ☐ Yes	2 No 3 Pro	bably 4 Unknown					
Vital Records,	w requir been si should	Completed	aladomial asiti	Chicasan		24a. Was an	24b. Were aut	opsy findings available					
Re	The lay	m d		- Cyche		autopsy performed	death?	ompletion of cause of					
ā		ပိ	25. Was case referred to medical		26 Place of Death	1 Yes 24	NO TOTES	2 140					
	Physician: this certific ral director,	To B	examiner?	ER/Outpatient 3 DO	Othor		e 6 Other (Speci	ifv)					
Q	y Phy er this		27. Manner of Death 28a. Date of Injury			28d. Describe how							
Ö	Attending F r death. ector: After by the funer	at le	Natural 5 Pending (Month, Day Year) 2 Accident investigation	njury M	1 Yes 2 No								
Division of	Attendi r death ector: A by the fu	ifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spi	t home, farm, street, factory,	, office	28f. Location (Stree City or Town, S	t and Number or Rui	ral Route Number,					
ā	al or s afte s Dir sd in	Certification:	4 Hornicos	Kiny)		ony or rount, o							
	To the Hospital or Attenwithin 24 hours after deati To the Funaral Director: completely filled in by the	cal	29a. Certifier (Check only 2 Medical Examiner: On the basis of exam										
	he H in 24 he F plete	edical	and manner stated										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c.	License number	29d.	Date signed (Month)	, Day, Year)					
			Ilmon o.	no	1008350	n	14728,	2006					
-	72		30. Name and address of person who completed cause of death (tem 23a) (Type, Print)	Har Sea DA	1 6.11	1. 1	11761					
	٨ "		G'DA'ITS PATRICIO	0403	and joice to	121/12	145 d	1234					
Ş		ite	31. Date filed (Menth, Day, Year)	gnature									
× ×	Regist		29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)										

State of Maryland / Department of Health and Mental Hygiene? [] [] [5]

For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death MAY 27 2006 Pear Physician 6:45pm DAVID GULICK NES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 15 CRESTLINE COURT OWINGS MILLS BALTIMORE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10XM 2□ F 89 Yrs 1917 PΆ 218-12-2261 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State or 28a-f show ijene. r than "natural", or iteme 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No MD BALTIMORE OWINGS MILLS Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21117 15 CRESTLINE COURT IISA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? □XYes 2 □ No Yes Give 1 1 Never Married 2 Married 1942-46 1□ Yes 2\no Specify: Baltimore, Maryland 21215-0036 Specify: WHITE <u>م</u> 3 ₩idowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DIPLOMAT DIPLOMAT 5 +... Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: If item 27 is marked other t jury or other treumatic event, In other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ETHEL BILLMEYER CHARLES M. NES, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 CRESTLINE COURT OWINGS MILLS, MD 21117 NANCY KNOWLTON daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Transport 1 Tra permit. Page Department of Importent: If eny injury or QDC&: PROSPECT HILL JUNE 2, 2006 YORK, PA 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHENRY W. JENKINS & SONS CO. 21. Signature of Funanti Se 16924 YORK ROAD MONKTON, MD 21111 ONACO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Break 7 tas month **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the el 1 ☐ Yes 2 ☐ No o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate of Vital 25. Was case referred o medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Mann Death 28d. Describe how injury occurred 28b. Time of Medical Certification: Division Injury 1 Matural 5 ☐ Pending n 24 hours after death.

The Funaral Director; After the function of the funct 1 Tyes 2 No investigation 2 ☐ Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 6301 annell lian 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

06-03382

Chukwudifu Anthony Nwobi

Please Type or Print in Black Indelible Ink

State of Maryland /	Department of Hea	alth and Mental Hygien

		1- For State Registrar		ate of Death	Reg. I	No. 2006 1701
Physicià Medical Examir		Decedent's Name (First, Middle, Last) CHUKWUDIFU ANTHON	Y NWOBI		2. Date of Death Month Da May 19, 2006	ay Year 0116 hrs
		4a. Facility Name (if not institution, give street and Doctors Community Hospital	d number)	4b. City, Town, or Location of Death Lanham		4c County of Death Prince George's
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24Hrs.	_	MM/DD/YYYY) 9. Birthplace (State or
Director		N/A 1XM 2	F 70	Yrs. Months Days Hours Min.	Oct. 25	, 1935 Foreign Country) Nigeria
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d Inside City Limits
faryland 28a-f show at once.	tor	Imo N/A 10e. Street and Number	Owerr			1 X Yes 2 No
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Director	#1 Obioma		10f. Zip Code N/A	_	Citizen of What Country? Nigeria
th with	uneral		Decedent Ever in U.S. d Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, 8lack, White, etc,
fter dea	ᄔᅵ	3 Widowed 4 Divorced If Yes, Give	es 2XX No	1 Yes 2 X No specify:	rtiodii, oto.)	Specify: Black
hours a	ed by	15. Decedent's Education (Specify only highest		Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retir		b. Kind of Business/Industry
036 thin 72 ne • than "	Completed		e (1-4 or 5+)	artered Surveyor	,	Surveying
filed wir		17, Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Maid	
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene n 27 is marked other than numatic event, the Medica	To Be	Nwobi Adigwe 19a Informant's Name/Relationship (Type, Print)	198	Christin b. Mailing Address (Street and Number or R		, City or Town, State, Zip Code)
more, MD 2 Pages I and 2 shoul ent of Health and M nt: If item 27 is m		Obika Nwobi / son	1	3069 Briarwood Drive	Laurel,	Maryland 20708
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 XXRemova	al from State cremate	of Disposition (Name of cemetery, ory or other place)	İ	Oc. Location - City or Town, State
Baltin permit Pr Departmer Importan injury or	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Sacred	Heart Church Cem. 6 22. Name and Address of Facility Donaldson Funeral		Oguta, Imo, Nigeria
		23a. Part I. Enter the disease, or complications the	/ M00770	313 Talbott Avenu	e Laurel	L. Maryland 20707
Physician /Medical		failure. List only one cause on each line.	atie marcescens		respiratory arrest, s	shock, or heart Approximate Interval Between Onset and Death
Fxaminer		or condition resulting in death) Due to (or a	as a consequence of):			
	iner	order-many net contamona,	eminated 1ym/ho as a consequence of):			
- A /=	Examiner	(Disease or injury that initiated C.	as a consequence of):			
wecuted an and I - transi	ledical E	d. Y UNPENDED AMENDE	D ====================================	07 ME COFC (/1 /oc mm		
760, feate be executed physician and the burial - trans	> I	IF FEMALE: 23c. If ye	es, outcome of pregnancy	27, perME, G856, 6/1/06 TI		23d. Date of delivery
Box 68760, death certificate by the attending physic defor use as the burned.		past 12 months?	e birth 2 egnant at time of death 5			Month Day Year
BO) the death the att the att	Physician		known			
P.C	اھ	Part II. Other significant conditions contributin	g to death but not resulting	g in the underlying cause given in Part I.		co use contribute to the cause of death? No 3 Probably 4 Unknown
ords, w requires been s should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal Recol	اق				performed	
ician: ician: s certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Inpatient 2 🗸 ER/Ou	26.Place of Death (Check or utpatient 3 DOA Other4 Nursing		idence 6 Other:
ing Phy After th	⊢ †	27. Manner of Death 28a. De			28d. Describe how i	
ision Attend r death. ector: by the f	catio	2 Accident Investigation	loco of Injuny. At home for	1 Yes 2 No rm, street, factory, office building, etc.	205.1	
Divis	Certification:	3 Suicide 6 Could not be determined (Special Special S		im, street, factory, office building, etc.	or Town, State)	t and Number or Rural Route Number, City
Fu Fu	edical	29a. Certifier 1 Certifying Physician: To the cone) 2 Medical Examiner: On the base	pest of my knowledge, dea	ith occurred at the time, date and place, and covertigation, in my opinion, death occurred at	lue to the cause(s)	and manner as started.
To the within To the comple	Med	and manne 29b. Signature and title of certifier	er stated.	29c. License number		d. Date signed (Month, Day, Year)
	ĺ	Potulieni - PE	Ileh m	O.C.M.E.	М	ay 19, 2006
	ľ	30. Name and address of person who completed of Patricia Aronica-Pollak MD. Assi	ause of death (Item 23a) stant Medical Exam	iner 111 Penn Street, Baltimore	MD 21201	
Sta			Registrar's Signature	TTT SIN Street, Daitinole		
Registr DHMH 17 Rev 1/200	_	MAY 3 1 2006	Sem &	Sparke		
- 1104 1/200	-		ORT	GINAL		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year OPALSKI BENEDICT MAY 10:25 PV 2006 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28, 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 XM 2 □ F Yrs Director 206-28-5347 69 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2011 Rockwell Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. withIn 72 hours after XYes 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1955-61 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Guidance Counselor Education permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benedict H. Opalski Anna M. Kempinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 Rockwell Avenue; Catonsville, MD 21228 Jean M. Opalski Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 6/3/2006 Hanover Twp., PA 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FAILURE CONGESTIVE DAYS /Medical Due to (or as a consequence of): Examiner CHEONIC UNKNUWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit ARTER10561EROTIC 3/ and ре ехесп Due to (or as a consequence of): Box 68760. Physician/Medical as the The law requires that the death certificate IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð pe MEZZITUS DIABETES 1 Yes 2 No 3 Probably 4 d Unknown this certificate has been si al director, page 2 should l Completed URINARY TRACT INFECTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HYPERTENTION Division of Vital 2 🗆 No 1 Yes 219 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2006 D 23300 130N SELUNES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1203P. PATEL 21223. SUDKIR 2000W 13A2TO 3T: 13A2TO MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sporte Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24,2006 12:33PM OBERI 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 8. Date of Birth (Month, Day, Year) HOSPITAL . AGNES timo RE Social Security Number 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 5 Months Days Min 249-90-5470 Usual Residence of Decedent 1**X** M 2□ F SOUTH Yrs 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MARULAND 10g. Citizen of What Country? 10e. Street and Number 2 6 70K 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 HIT GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code, 625 N 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City r Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reson myoLo Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Liner Unionying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 FR/Outpatient 3 □ DOA 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

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filed within 72 hours after death

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, The Mading Once.

Baltimore, Maryland 21215-0036

Funeral Director

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or Attending Physician: filled in by the funeral director, After Division within 24 hours after death. To the Funeral Director: A

Physician/Medical Completed

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State Registrar

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titte of certifier

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

Marsh 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) DVNDT 120

31. Date filed (Month, Day, Year) 2006

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		For State Registrar		State of	Maryland		artment of F		and Men		ene	06	17015)
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	4	30. Name and address of person who completed cause of death (Item 23a) (Type, Pi	m 2/23	May DR. Pingli	
	0	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1110 420	/ GA	
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Baltimore, Mai	permit. Pages 1 and 2 sl Department of Heath and Important: If Item 27 is r eny injury or other traur once.		19a. Informant's Name/Relation Philip Rouchar 20a. Method of Disposition 1 □ Buriaf 2 □ Cremation 4 ☒ Donation 5 □ Other (d/spous 3 □Remova	e			thori	dge	Rd.	Luth	a <i>l Route Numb</i> <u>erville</u> Date	, MD			
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8760,	Physician /Medical Examiner the privat-transit of the privat-transit of the privat-transit of the private of t	ilcal Examiner	23a. Part1. Enter the disease, shock, or hear failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. A	OLUNA	MY a consequence of consequence of SCL	ience of): AND ience of): ENOT	M my	WF	im co	Пи =				Int	proximate erval Between set and Death
P.O. Box 6	w requires that the death certific; been signed by the attending pl should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	es, outcome o Live birth 2 Pregnant at t Unknown	2 Fetat	death 3	⊒Ectopic pr ⊒ Other (sp					23	3d. Date of o	defivery Day	y Year
	quires that t an signed by uld be detac	by	Part II. Other significant condit		ng to death bu	it not resu	ofting in the u	Inderlying c	ause give	en in Part I	l.		tobacco us	/		ause of death?
al Records,	n: The law re icate has bee r, page 2 sho	Completed										24a. Was auto perf 1 \(\text{Yes}		prior t death	o comple	findings avaitable etion of cause of] No
Division of Vital	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be	3 Suicide 6 Could	Hospital 28a	Date of Injur (Month, Day) Ptace of Injur	Year)	ER/Outpaties 28b. Time of Injury	of 2	8c. Injury Work	9r: 4 □ Nu	ursing Ho	h (Check only) me 5 Res 28d. Describe 28f. Location City or To	idence 6 how intury	occurred		oute Number,
Ω	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical Cer	29a. Certifier Certify (Check only 2 Medica	ng Physician: I Exeminer: Or	To the best on the basis of dimanner state	examinat	wledge, deat ion and/or in	h occurred	at the tim	ne, date an	nd place,	and due to the	cause(s) a	ind manner place, and d	as stated	d. e cause(s)
)	To the within To the Comple	Me	29b. Signature and title of certific	er/M	wi	2		3) 15	number			Mar	signed (Mo	onth, Day	(, Year)
	-		30. Name and address of person 5501 LOUF 12 31. Date filed (Month, Day, Yea MAY 3 1	who complete	d cause of de	ath (Item	23a) (Type,	Print) NS, N	10	MELU 212:	39	P. SUT	TM	D		
J. S.	Sta Regist		MAY 3 1	2006	SZ. Registra	r's Signa	ure Go									

DHMH 17 Rev 1/2001

State of	Maryland /	Depa	artme	nt of	Healt	h and	Mental	Hygien	ļ
		_	. 1 . 1		-				

			For State Registrar	State of Mai	-	artment of rtificate of		Mental Hygi	ene g. No?	17019
	Physici /Medic		1. Decedent's Name (First, Middle, La Priscilla N. R	•				2. Date of Death Month May 20	Day Year	3. Time of Death 1:37 pM
	Examir		4a. Facility Name (If not institution, give Montgomery Hos		y House	4b. City, Town, RockV	or Location of Dea	th	4c. County of Death Montgome	ery
	Funeral Director			Sex I□M 2只F	(In yrs. last birthday) 60 Yrs.	If Under 1 Yea Months Days				place (State or Foreign ntry) Deria
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl e-f sho	tor	MD Montgo	mery	Kensing	rton				1 ☐ Yes 2√€XNo
	or 28c	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	ntry?
	s 23a	rall	3907 Hampden S		in II C 12.1	2089			iberia	an ladia
39	72 hours after death with the Maryland natural; or Items 23a or 28e-f show Iteal Examiner must be notified at	by Funeral	11. Marital Status **Mever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		was Decement of f Yes, specify Cu 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. Race - Amen Black, White, Specify: B1 a	etc.
Maryland 21215-0036	unithin 72 hours after death with the Marylan liene. I then atural; or Items 23a or 28e-1 show Ite Madical Examinet must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retir	during most of wo	orking	6b. Kind of Business/Ir	dustry
2	e filed wi Il Hygien other th		10 9	1	Che	ef	10 Math ada No		Priva	te
and	D 50 0	o Be	Timothy Reev				Unkne	me <i>(First, Middle, M</i> a OWN	aiden Surname)	
Mary	ges 1 and 2 should be it of Health and Mental : if item 27 is marked o or other traumatic eve	2	19a. Informant's Name/Relationship	Type, Print)	19b Mailin 8807 Gait	og Address (Stree Cross hersbu	t and Number or R		City or Town, State, Zip	Code)
Je,	es 1 and 2 of Health a fitem 27 is r other trace		20a. Method of Disposition	EWIT FEASA VISE IN	20b. Place of Dispo	sition (Name of natory or other pl	ace)		0c. Location - City or To	own, State
Baltimore,	nit. Pages lartment of l ortent: If its injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	5)	Gate of	Heave:	n 06-		Silver Sp	
Ball	permit. Page Department of Importent: If any injury or once.		21. Signature of Juneral Service ace	Bolime	10	Ronard 583 Mi	*Taylor ddlepor	II Fune Ln. Wh	ral Chape ite Plain	as, MD
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line	ne death. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
68760,	Medical pe executed titicate pe executed by physician and strensit as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of): consequence of):					
O. Box	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	Sy .		23d. Date of deliver	ery Day Year
Δ.	w requires that the been signed by the should be detache	<u>م</u>	Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause g	ven in Part I.		cco use contribute to t	
Division of Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of 2 No
V II a	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hegaital:				ath (Check only one)		
וסר	g Phys ter this neral dir	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatien 28b. Time of Injury	28c. Inju		lome 5 Residen	ce 6 StOther (Specific injury occurred	Mospice
IVISIO	or Attending I after death. Director: After in by the funer	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	n 29a Blace of Injure	y - At home, farm, stre	M 1]Yes 2 □No	28f. Location (Stre City or Town,	et and Number or Rura State)	d Route Number,
	Hospitel 4 hours a Funeral ely filled	edicai Cer	29a. Certifier 1 X Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of miner: On the basis of e	xamination and/or inv	occurred at the restigation, in my	ime, date and place	e, and due to the cau	se(s) and manner as s e and place, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner state	su.	29c. Licen	se number	290	d. Date signed (Month,	Day, Year)
	⊢ s ⊢ ŏ \		· HV	~ W	CI	D350	535		lay 23, 2	. ,
	Ø		30. Name and address of person who					D - 1	7.7	2225
	Sta	ite	Joseph Kaplan, 31. Date filed (Month, Day, Year)	M.D., 6	01	aster N	ITTT KO.	, KOCKVI	lle, MD	20855
	Registr		MAY 3 1 2	1116 Marchae	· IF AG					

Physician James Richardson	2. Date of Death Menth Day Year 3. Time of Death May 26, 2006 2 45 PM
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director 5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs. ast birthday) 10 Vrs.	8. Date of Birth Month, Day, Year 30 May and May and May and
100 City Town at acation	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
10a. State. 10b. County 10c. City, Town or Location Baltimore 10a. State. 10b. County 10c. City, Town or Location Baltimore 10a. State. 10b. County 10c. City, Town or Location Baltimore 10b. Zip Code 21215 11. Marital Status 11. Marital Status 11. Marital Status 11. Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 (DVes 2 DVes	10g. Citizen of What Country?
11. Marital Status 12. Was Decedent Ever in U.S. Armed Torcas? 13. Was Decedent of Hispanic Origin? (Specify Cubac Mexican, Puerto R I Yes, Specify Cubac Mexican, Puerto R	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specity: Dack
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name	Pepsi Cola
Tr. Father's Name (First, Middle, Last) 18. Mojher's Name Replace And Part of Charles Alchardson 18. Mojher's Name Adelaids	(First, Middle, Maiden Surname) EBOCKINGTON
19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Chauncel Nichardsin—Son 4D17 Elderon Avc. 20a. Method of Disposition 20b. Place of Disposition (Name of complete, crematory or other place)	Battimere, Maryland 200
100. Street and Number 101. Zip Code 102. Zip Code 102. Zip Code 103. Zip Code 104. Zip Code 104. Zip Code 105. Zip Code 106. Zip Code 106	20c. Location - City or Town, State 2-06 Owings Mills Maryla er Fueral Hone, P.A., 212
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death:
Cause. Enter Underlying Cause. Letter Underlyi	23d. Dale of delivery Month Day Year
Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
n: The law requirements to page 2 should Completed Completed	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medicat examiner? 1	
27. Manner of Death Could not be determined 28a. Date of Injury 28b. Time of Injur	8d. Describe how injury occurred
3 Suicide 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	 Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the lime, date and place, and place, and manner stated. 29b. Signature and title of certifier 29c. License number.	d at the time, date and place, and due to the cause(s)
Plumar M49611	29d. Date signed (Month, Day, Year) 5/30/0 (
21 Date filed (Month Day Vers) 20 Clasiaterds Cinneture	Itimore, Mary land 2121
State Registrar MAY 3 1 2006 DHMH 17 Rev 1/2001	,

			State Registrer	te of Maryland /		artment of l tificate of			Re	g. No.	16	170	121
	Physici	an	 Decedent's Name (First, Middle, Last) Mary Theresa Rowinsk 	i					Date of Death Month 1ay 2:	Day 1	rear	3. Time of 9:45	Death A M
	/Medio	ai	a. Facility Name (If not institution, give street a	nd number)		4b. City, Town,	or Location of		iay Z	4c. County of	Death	9.45	A
1			Hospice of Baltimore	Gilchrist Ce		Towsor		24 Hrs 0	Date of Risk	Baltim		1 (01-1	- F /
	Funeral Director		5. Social Security Number 6. Sex 116-26-3886		Yrs.	Months Days		Min.	Date of Birth (Month, Day,	1935	New	lace (State of try) York	r i-oreign
	pug 🔉		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Lo	cation					1	0d. Inside Cit	v Limits
	Manyla -f sho	tor	NY Nassau	2.		yster Ba	ıv				,	1 🗌 Yes	
	or 28e	Direc	10e. Street and Number			10f. Zip Code	<u>, </u>		10	g. Citizen of Wh	nat Coun	itry?	
	death with the Maryland ms 23a or 28e-f show rmust be rudified at	Funeral Director	34 Preston Lane	Decedent Ever in U.S.	13 \	11791	Hispanic Ori	gin? (Specify	y Yes or No-	USA 14. Race	- Americ	an Indian	
5-0036	urs after el', or Ite Examina	by	1 Never Married 2 Married 1 If Y	ed Forces? Yes 2/10 No es, Give r or Dates:	- 1	Vas Decedent of f Yes, specify Cub I ☐ Yes 2 No			an, etc.)		White,		
5-0	4 30	ieted	15. Decedent's Education (Specify only highest grade comp		. Deced	lent's Usual Occu kind of work done OO NOT use retire	pation during mos	t of working	1	6b. Kind of Bus	iness/Ind	dustry	
2121		Completed	Elementary/Secondary (0-12) Col	ege (1-4or 5+)		acher	эа)			Educatio	on		
nd	be filed withlital Hygiene. Id other then	Be C	17. Father's Name (First, Middle, Last)							aiden Sumame,)		
Maryland	2 should be f and Mental i is marked of raumatic eve	10	Joseph Vangreen 19a. Informant's Name/Relationship (Type, Prin	(r) 19	h Mailir	g Address (Stree	1	ine Go		City or Town S	tate Zin	Codel	
	日本に		,,,,,			nathans							
Baltimore,	0 0	1	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Remova	from State 20b. Place cemete	of Dispo	sition (Name of natory or other pla	ace)	Date	2	Oc. Location - C	ity or To		
Iţi	Part and ury		* 4 ☐ Donation	Calver		Nationa Name and Addr		5/5/06	C	alverto 1050'			
Ba	permit. Departr Importe any inj		rety -a.	~		uck Tows		-	Home			D 2120	4
	Priysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition a.	that caused the death. Do on each line.		er the mode of dy		cardiac or re	espiratory arres	st,	l	Approximate Interval Betv Onset and D	veen Death
	/Medical Examiner		resulting in death)	ue to as a consequence		CE-CITITION WINDS							•
	D H	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence	of):								
_	certificate be executed iding physician and a se the burial-transition	Examiner	that initiated events C.	ue to (or as a consequence	of):						-		
8760,	sate be e physician the buris	dicai E	d										
0	n certificat anding phy use as th	ě l	IF FEMALE:										
.o. Box	the death y the atter iched for u	Physician/M	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal deat Pregnant at time of death Unknown		Ectopic pregnand Other (specify)	СУ	-		23d. Date Monti		•	ear
ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing	g to death but not resulting	in the u	nderlying cause g	ven in Part I.			acco use contrib ; 2 □ No 3		e cause of de ably 4 □U	
I Records,	The law ate has b page 2 sl	Completed							24a. Was an autopsy perform	ed? de	ere autor or to cor ath? Yes	osy findings a npletion of ca 2 No	vailable use of
Vital	Physicien: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 SoNo Hospital	1 ☐ Inpatient 2 ☐ ER/O	utnation	t 3 DOA			heck only one	ce 6 20ther	(Canait	three	21-
ion of	ding h. After fune	ertification; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b.	Time of Injury	28c. Inju	4 🗆 140	28d		v injury occurred		TIUSE	PICE
Division	or Dir	O	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, f building, etc. (Specify)	arm, str	eet, factory, office		28f.	Location (Stre City or Town,	eet and Number State)	or Rura	l Route Numb	oer,
,	do the house	edicai	29a. Certifier (Check only one) 1 Cartifying Physician: 2 Medical Examiner: Or an	To the best of my knowledg the basis of examination a d manner stated.	ge, death nd/or in	occurred at the treatment occurred at the treatment of th	ime, date an opinion, dea	d place, and th occurred a	due to the cau at the time, dat	ise(s) and manr e and place, an	ner as st d due to	ated. the cause(s)	
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			1	se number	3	I	d. Date signed (
	17		30. Name and address of person who complete		(Туре,				es Since				
	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's Signature		/	OWSON	v, mi	D. 212	04			
:	Regist	rar	31. Date filed (Month, Day, Year)	war it s	284	Le la							
DH	MH 17 Rev 1/2	001							-				

			For State Registrar	State of Maryla		artment of F			tal Hygier	4000	17022
			1. Decedent's Name (First, Middle, L	ast)					Date of Death	Day Yea	3. Time of Death
	Physici: /Medic		CHARLES OT	TO RABEL					May 25.	2006	2:00 A ^M
}	Examin		4a. Facility Name (If not institution, go	ve street and number)		4b. City, Town, o	or Location of	of Death		4c. County of De	eath
	Funeral		HOSPICE OF BALTI 5, Social Security Number 6.		CENTE	If Under 1 Year		1 24 Hrs. 8. [Date of Birth Month, Day, Ye	Baltimo	re County Birthplace (State or Foreign Country)
	Director		212-05-7021	¹ Дм ² □ F 9	2 Yrs.	Months Days	Hours	Min. F	eb~8,~19	317.	aryland ———
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				LIC	10d. Inside City Limits
	Aaryla Febor	ច				ltimore					1 ☐ Yes 2 ☐ No
	the the 28a-	Funeral Director	Maryland Baltimo	re County	Da	10f. Zip Code			10g.	Citizen of What	Country?
	3a or	<u>-</u>	309 Hopkins Roa	d			21212)		USA	
	death ms 2	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I			Yes or No-		merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, Ite Madical Examinar must be maillised at ance.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No			11, 0.0.7	Specify:	White
21215-0036	hour	ed b	15. Decedent's		16a. Dece	ident's Usual Occup	pation		16b	. Kind of Busine	ss/Industry
75	nin 72 In "ne	Completed	(Specify only highest g	rade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during mos nd)	it of working			
7	od with	E O	Elonionally (5 12)	5+	Co	- Proprie	etor			Auto S	ales
Maryland	be file	Be	17. Father's Name (First, Middle, Las					12.00	rst, Middle, Maid		
y la	should and Men s marke umatic	2	Charles 19a. Informant's Name/Relationship	Rabel	10b Maili	ing Address (Street		iguste	uta Numbar, Cii	Klems	
Z	d 2 st th and t7 is r traur	Y f	Mrs. Elizabeth R			Horkins I					
	Health tem 27 tothar tra		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other pla	Modu,	Date		Location - City	
OE .	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State		ount Ceme		5/26/2	2006 Ba	ltimore	, Maryland
altimore,	partm porta		21. Signative of Funeral Service Lie		2	2. Name and Addre	ess of Facili	ty			•
<u> </u>	89 5 8		Martin D.	WSON		Mitchell- 6500 Yorl	-wiede	reid r	imore	nome, I Marvlan	1 21212
			Martin D. 23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de y one cause on each line.	ath. Do not en	ter the mode of wi	ng, such as	cardiac or res	spiratory arrest,	LELL J LONE	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	-a. ASDI		on pi	100	mon	in		Onget and Death A 4 5
	/Medical Examiner		resulting in death)	Due to or as Lonse	equence of):	ngen	1 1	450	GAZI	A	Langues
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of):	111964	(()	7-1		, ,	wores
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	· 5+	DKE	5					years
0	death certificate be executed e attending physician and nd for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	cate by	Physician/Medical	•	d							
9	eath certific attending p for use as I	/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy					23d. Date of	delivon.
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3[□Ectopic pregnand □ Other (specify) _	у			Month	Day Year
P.O.	that the de ned by the a detached f	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						21-21 VOLENIE	
	res that igned b	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause gr	ven in Part I	l.			to the cause of death?
ord	law requires as been sign 2 should be								1 🗆 Yes	2 LETNO 3 L	Probably 4 Unknown
ec	has be ge 2 sh	Completed							24a. Was an autopsy performed	24b. Were prior death	autopsy findings available to completion of cause of
al F	T ate								1 Yes 2 ₩		es 2 No
Vit		o Be	25. Was case referred to medical examiner?	Hospital:	Tenie:				neck only one) 5 ☐ Residence	.5/	Hospics
of		H	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2	28b. Time o	111 3 DOV	4 🗀 140	-	Describe how in		peciny) //USF/CE
ion	Attending Phrdeath.	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury		ink?]Yes 2□	No			
Division of Vital Records,	or Attendated death Director:	ertification;	3 Suicide 6 Could not determine	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office			Location (Street City or Town, St		Rural Route Number,
Ω	urs af urs af arat D	0		The state of the s					due to the server	-(-)	
	To the Hospital or Attending the Hours after de To the Funeral Directo completely filled in by the	edical		Physician: To the best of my k aminer: On the basis of exami and manner stated.							
	To th within To th comp	Me	29b. Signature and title of certifer	11 10		29c. Licen	se number	\ , —		Date signed (Mo	
-			1/1/ HV	They ful) (V	790	<u>.</u>	0	-	5,2006
	25		30. Name and address of persen wh	o completed cause of death ()	em 23a) (Type		-		JIREET		
	1.	ato.	31. Date filed (Month, Day, Year)	32 Sepetrar's Sig	nature		vson,	MD Z	1204		
	Sta Regist		MAY 3 1 2		H A	naule					

2:00 Any

5/25/06

Rabel, Charles

			1 - For State Registrar	State of Marylan	-	artment of F			giene Reg. No.2006	17023
	Physici /Medic		1. Decedent's Name (First, Middle, Las	t)		Salabua	24	2. Date of Dea Month	Day Year	3. Time of Death 3.45 AM
	Examir		4a. Facility Name (If not institution, give 10 hrs. Hofking 5. Social Security Number 6. Second 1997)	HOSPITAL ex 7. Age (In yrs.	last birthday)	BA/+//	NONE If Under 24 Hrs. Hours Min.		4c. County of Deat	h hplace (State or Foreign untry)
	Director		223-40-8429 Usuel Residence of Decedent	XM 2□F 69		Months Days	Hours Min.		3/1936 VA	unity)
Maryland	a-f show	ctor	10a. State 10b. County MD		y, Town or Lo ALTIM					10d. Inside City Limits 1 XYes 2 No
dit.	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
d d	38 23 Files	eral	1 N. CLINTON S	12. Was Decedent Ever in U	.S. 13.	21224 Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	USA 14. Race - Ame	rican Indian,
336 Is affer d	i, or item	ρ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates:		Was Decedeni of H If Yes, specify Cuba 1 □ Yes 2 No		o Rican, etc.)	Black, White Specify: BL	e, etc.
21215-0036 States death with the Maryland	Theilth and Manual Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Madical Examiner must be notified.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of word)	rking	16b. Kind of Business/	
CI S	Hygien ther th ent, the		12TH 17. Father's Name (First, Middle, Last)		BRI	CK MASO		no (First Middle	CONSTRUC Maiden Sumame)	CTION
<u>a</u>	Mental F arked ot atic aver	To Be	REV. ROBERT SA	ALISBURY			NORMA	VENNEY		
Mary	h and		19a. Informant's Name/Relationship (7	Type, Print)					er, City or Town, State, 2	1
ore,	0		MARY WALTOR 20a. Method of Disposition 1 \(\overline{\infty} \) Burial 2 \(\overline{\infty} \) Cremation 3 \(\overline{\infty} \)	Removal from State	Place of Dispo cemetery, crea	esition (Name of matory or other place	ce)	Date	MORE MD 20c. Location - City or	
Baltim	Department Important: if any injury o		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		22	2. Name and Addre	ss of Facility WE	SLEY CH	OWINGS M	FNRL. HM
P	hysician		23a. Part1. Enter the disease of comp shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that raused the deat one cause on each line.	h. Do not ent	er the mode of dyir		or respiratory ar	LTIMORE, N	Approximate Interval Between Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a conseq			arction			Iweek
8760,	hysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c						
.O. Box 687	the ettending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ideath 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of del Month	ivery Day Year
<u>م</u> ۽	6 6 8	ρ	Part II. Other significant conditions o	ontributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.		obacco use contribute to	
Division of Vital Records,	te hes t age 2 s	Completed								itopsy findings available completion of cause of 2 No
/ita	certifice rector, p	Be	25. Was case referred to medical examiner?					ath (Check only o	ne	
of Vita	this le	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier		4 Nursing F		dence 6 Other (Special Company)	cify)
sion	After	ertlfication;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	M 1	yat rk? Yes 2 □ No			
Divi	irs efter deat rai Dirsctor: led in by the	O	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	ome, tarm, sti (y)	reet, factory, office		City or Tou	Street and Number or Ru wn, State)	ural Houte Number,
	within 24 hours effer of All to the Funeral Director Completely filled in by	edical	(Check only one) 2 Medical Exam	yulcian: To the best of my link niner: On the basis of examina and manner stated.	wledge, daut ition and/or in	h conurrad at the til vestigation, in my o	nie date sind plane opinion, death occu	and dua to thai urred at the time,	date and place, and due	to the cause(s)
- 2	within 2 To the	Σ	29b. Signature and title of certifier	10		29c. Licens		!	29d. Date signed (Monti	
•			Channing Va	lle 1		IKES	-00	/	11/AY 22,	2006
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	Ballin	er 11/2	May 22,	51247
		ate	31. Date filed (Month) Day, Year) MAY 3 1 2006	32. Registrar's Signa	ature	J. A	14171166	re, IIIM	1	6168/
1	Regist	rar	MHI 2 T 5008	Storme I.	don	off 1				

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H rtificate of I			giene Reg. No. 2 🗍 🏻	06 170
	1	. Decedent's Name (First, Middle, La	t)				2. Date of De Month		3. Time of Deat
Physician	L	Jessie <u>May Shephe</u>	rd				05/28		12:01 A
/Medical	4	a. Facility Name (If not institution, giv	street and numbe	or)	4b. City, Town, or	Location of Deat		4c. County of	
Examiner					Catonsvi	110		Baltimo	re
		07 Maiden Choice Social Security Number 6. S	ex 😽 7.7	Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th Vear	9. Birthplace (State or Ford Country) Mary1an
Funeral Director	- 1	217-01-6223	□м 21□ F	86 Yrs.	Months Days	Hours Min.		7/1919	Marylan
	ī	Jsual Residence of Decedent							1
yland	1	0a. State 10b. County		10c. City, Town or L					10d. Inside City Lin 1 ☐ Yes 2 🔯
Mar tor		MD Baltimo	re	Catons	ville				X
r 286	1	0e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
Mill Mill Mill Mill Mill Mill Mill Mill		707 Maiden Choice	Lane.		212	27		USA	
ed within 72 hours after death with the Maryland Ygiene. Nor than "natural", or items 23a or 28e-f ehow it. Ite Medical Example at must be notified at Completed by Funeral Director		11. Marital Status	12. Was Decede Armed Force		Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)		- American Indian, White, etc.
Fu Fu		1 Never Married 2 Married	1 ☐ Yes 24		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
Tal', c		3 Widowed 4 Divorced	Year or Date						
72 hc		15. Decedent's E (Specify only highest gro	ducation ide completed)	(Giv	edent's Usual Occup e kind of work done	during most of wo	rking	16b. Kind of Bus	iness/industry
opid.		Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retired	a)		Social S	Security
od wi	3			Cle	ĽK.	40 Markada Na	- (Circt Middle	o, Maiden Sumame	
Be file		17. Father's Name (First, Middle, Last)			Elena		, Malueri Sumame	,
Ment Ment arked	2	Unknown							
nd 2 sho lith and I 27 is me	1	19a. Informant's Name/Relationship Wayne Shepherd	Type, Print) Son	19b. Mai 65	ling Address (Street 70 Fruitg	and Number or A iff: Place	e. Colum	ibia, MD	21045
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-1 show any injury or other traumatic event, the Medical Eventh attribute be notified at once. To Be Completed by Funeral Director	-	20a. Method of Disposition M Burial 2 Cremation 3 [110	ematory or other pla		Date /01/06	Baltimo:	city or Town, State re MD.
ermit. Pages 1 ar Department of Hea mportant: If item iny injury or othe	-	' 4 □ Donation 5 □ Other (Special Signature of Pulper Secucio Line			dge Cemet 22. Name and Addre		1 D-w	1. 17	1 11
permi Depa Impo any ir		om amand	2						
485 44	4	23a, Part1. Enter the disease, or con	1:1: 1b -1	and the death. Do not a	620 Wilke	ns Ave.	c or respiratory	rest	Approximate Interval Between
icate be executed physician and sthe burial-transit sthe burial-transit cidical Examiner	LYG	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequence of): as a consequence of): as a consequence of):					
Attending Physicien: The law requires that the death certificate order. setor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the Hicarion: To Be Completed by Physician/Medic	nysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ☐ Fetal death 3 nt at time of death 5	3 □Ectopic pregnanc 5 □ Other (specify) _	у		Mon	
w requires that the s been signed by the should be detached by Physoleted Physoleted Physical Physic	2	Part II. Other significant conditions	contributing to dea	th but not resulting in the	underlying cause gi	ven in Part I.			bute to the cause of death 3 ☐ Probably 4 ☐Unkn
or Attending Physician: The law requires taffer death. Director, After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	ete						24a. Wa	s an 24b. W	/ere autopsy findings avai
e lav	E						_ рег	formed? d	rior to completion of cause eath?
Color	3						1 ☐ Yes	- 7	Yes 2 No
cian ertiffi actor	P	25. Was case referred to medical examiner?	Hospital:		Ot	hor	eath (Check only		
hysis this c	0	1 ☐ Yes 2 No	1 1 I Int		IBIT 3 DOA	4 C Huising		sidence 6 Other	
Mter After Ingre	ü	27. Manner of Death ↓□Natural 5 □ Pending		Day Year) 285. Tille	y Wo	ork?]Yes 2∐No	250. 5050/150	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-
tendi or: A the fu	cat	2 Accident investigate 3 Suicide 6 Could not		//			28f Location	(Street and Number	or or Rural Route Number,
tal or Attending P rs after death. el Director, Atter ted in by the funera		4 Homicide determine	d 200. Flace 0	if Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory, office	l		own, State)	or rigidal rissis rising an
5 5 9 9 C	Medical Ce	(Check only 2 Medical Ex	eminer: On the bas	pest of my knowledge, desis of examination and/or	eath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the	e cause(s) and mai e, date and place, a	nner as stated. nd due to the cause(s)
the lin 2 the lin 2 the lin 2	Jed	one)	and manne	51 StateU.	29c. Licen	se number		29d. Date signed	(Month, Day, Year)
To To		29b. Signature and title of certifier			DY			May 3	U 7.70
1			, un					1 , 7 ,	1 2001
5		30. Name and address of person wh	completed cause	of death (Item 23a) (Type Victoria)	De. Print)	Lary	(9	tens vil	p Wept.
State Registra		31. Date filed (Month Ray, Year) 1	2006 32 40	gistrar's Signature	Joseph				

		For	State of Maryla					Mental Hy	giene)	006	1702	E
		1 = Stata Registrar		Ce	rtificate	of Dea	ath	2. Date of De	Reg. No.		3. Time of Death	_
Physic	ian	1. Decedent's Name (First, Middle, Last	Szeka	leki				Month A	Day	Year 2006	- 1/ -	
/Med Exami		Anthony 4a. Facility Name (If nor institution, give		1311	4b. City, T	own, or Loca	ation of Dea			unty of Death	6.1	
Exami	iiei		putal	-	Bai	tzm	ore			VIA		
- Funera		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday	If Under 1 Months		Jnder 24 Hr ours Mir		th y Year)	9. Birthpl Count	ace (State or Fore	gn
Director		Usual Residence of Decedent	Xim Zu i	67 Yrs.				November	26, 193	Maryl	and	
land ow		10a. State 10b. County	10c.	City, Town or L	.ocation					10	d. Inside City Limi	ts
Mary a-f eh	Ş	Maryland N/A		Baltim	ore						1 X Yes 2□1	10
13-UU30 72 hours after death with the Maryland 72 hours after death with the Maryland 7 haturel; or Items 23a or 28a-f ehow	Directo	10e. Street and Number 6508 Brown Avenue		•	10f. Zip (224			-	of What Count JSA	ry?	
death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decede	ent of Hispan	nic Origin? (Specify Yes or No)- 14.	Race - America Black, White, e		
If A LA IS-0030 filed within 72 hours after Hygiene. ther then "naturel", or ite out, the Madical Examilia	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 Yes 2		ecity:	, 10 1 10411, 010.)		ecify: Whi		
2 hour	led t	15. Decedent's Ed	ucation	16a. Dece	edent's Usual	Occupation			16b. Kind	of Business/Ind	ustry	
hin 7:	Completed	(Specify only highest grad	College (1-4or 5+)		e kind of work DO NOT use		g most of w	orking		_		
ed will ygien t, the	S	12 years	2 years	M	echani		11.16.1.1.11	(F)	Ste			
	Be C	17. Father's Name (First, Middle, Last) Anthony Szekalski						ame (First, Middle a Michals		name)		
Earylari 2 should be and Mental 1s marked is umaric ev	5	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ling Address (-		Rural Route Numb		wn, State, Zip	Code)	
Malth and 2 st all the and 27 is an artraum		Earlaine Szekalski	wife	6508	Brown	Avenu	ue, Ba	ltimore,	Mary	Land 2	1224	
of He fitem		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐	Damoual from State	b. Place of Disp cemetery, cre	ematory or oth	her place)	Ju	ne 1,	20c. Locati	on - City or To	wn, State	
Pag ment ment mant: b		4 □ Donation 5 □ Other (Specify)	ayview				2006		nore Ci		
Baltimore, permit. Pages 1 ar Department of Hez Important: If item any injury or othe		21. Signature of Funeral Service Licens	Connel	les o	onnell 110 So	y Fune 11ers	Facility Point	Nome Of D	undall undall	c,P.A. c,MD. 2	1222	
		23a. Part1. Enter the disease, or or mp shock, or heart failure. List only of	fications that caused the d								Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	4	icula	er	arr	4+1	nmia	-		Onset and Death	
/Medica Examine		resulting in death)	Due to (or as a con			-	0					
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con-	sequence of):				····				
ansit A da	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
ate be executed assician and the burial-transit		resulting in death) Last	Due to (or as a con-	sequence of):								
8 / 6U ate be e hysician the buria	lcal	•	d									
. BOX 687 death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	agnancy					224	Data of dalisa		
BOX leath cer attendir I for use	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3	□Ectopic pre				230	Date of delive Month	Day Year	
oy the achee	hysi	1 Yes 2 No 9 Unknown	9□ Unknown									
COrds, P.O. By wequires that the death been signed by the atte	5	Farm. Other significant conditions of	entributing to death but not	resulting in the	underlying ca	iuse given in	Part I.	23e. Did t			e cause of death?	wn.
requi	eted							2 77				-
He lay	Completed								psy ormed?	prior to con death?	esy findings availat apletion of cause of	f
VITAL P sician: Th certificate rector, pag	a	25. Was case referred to medical				26.	Place of D	1 Yes	2 No one)	1 🗆 Yes	2□ No	
- 8 × 5	To B	examiner?		Outpatie			□ Nursing	Home 5 ☐ Resi	dence 6	Other (Specify)	
E grand		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury		Bc. Injury at Work?	0 (This	28d. Describe	how injury or	curred		
LIVISION I or Attending after death. Director: After	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home farm s	M treet factory	1 Tes	2 🗆 NO	28f. Location (Street and N	umber or Rura	Route Number,	
al or A safter of DIV	Certification:	4 ☐ Homicide determined	building, etc. (Sp	pecify)	area, radiory,	Onioc		City or To	wn, State)		, , , , , , , , , , , , , , , , , , , ,	
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical (/sician: To the best of my iner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ath occurred a nvestigation,	at the time, d in my opinio	ate and plain, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as stace, and due to	ated. the cause(s)	
ro the within ro the	Me	29b. Signature and title of certifier			29c.	License nur	mber		29d. Date si	gned (Month, L	Day, Year)	
->-0		1930 aut	P, NID.		I	0005	5372	27	MAY	254	2006	
J.		30. Name and address of person who	completed cause of death ((Item 23a) (Type	e, Print)	e.l.2 01/	00 0	word D.	no Oto	ملا حدم	Innilian	1.
100	ļ	Jessica Wyan-	7 MU 36	101 500	Hh Itt	JUVO	וצ ז	TELL IX	XX 12 IV	LOIC V	7122	_
S Regis	tate trar	31. Date filed (Month, Day, Vear) MAY 3 1	completed cause of death (HD) 30. Registrar's S	Jana Jana	No. of the last of						G. 50	

			For Stata Registrar	State o	of Marylar		artment of H rtificate of I				16	17026
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physicia		1. Decedent's Name (First, Middle, Lydia P. Stei						2. Date of Death Month May	_	ear	3. Time of Death 12:48 PM
y	/Medic		4a. Facility Name (If not institution,		mber)		4b. City, Town, or	Location of Death	riay	4c. County of		12:40 F
	LXAIIIII		Anne Arundel				Ann	apolis		Ann	e Ar	undel
	Funeral Director		578-01-9138	6. Sex 1 ☐ M 2 ₹ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 30,	Year) 1916	9. Birthpl Coun Virg	ace (State or Foreign try) inia
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation	· · · · · · · · · · · · · · · · · · ·		<u></u>	10	Od. Inside City Limits
	Mary Ind	tor	Maryland Montgo	merv		Sil	ver Sprin	ζ.			1	1 ☐ Yes 2 ☐ No
	th the or 28s	Directo	10e. Street and Number				10f. Zip Code	0	10	g. Citizen of Wh	at Coun	try?
	ath wi	rai	11709 Caplinger		· · · · · · · · · · · · · · · · · · ·		. 209			USA		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, Ita Medical Examinat must be multified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Fo	ve		Was Decedent of H If Yes, specify Cuba 1□ Yes 2∰No	ispanic Origin? (Spo in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	America White, a Whi	etc.
5-0	72 hc	Completed	15. Decedent' (Specify only highest	's Education t grade completed)		(Give	dent's Usual Occupa	durina most of work	ing 1	6b. Kind of Busi	ness/Inc	lustry
121	within iene. than	шрі	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Estate A	•		Real	Fato	to
d 2	filed Hygid other ent, II	a	17. Father's Name (First, Middle, L	Last)		Real	LState A	18. Mother's Name	(First, Middle, M			ite
Maryland	2 should be and Mental Is marked c	To B	William Poole	ž				Carr	ie Poole			
lary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationsh				ng Address (Street					
	and: lealth m 27		Edgar Snyder, S	Son	201-		Riverside					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	State	cemetery, cres tro Cre	esition (Name of matory or other place ematory I	nc. 05/3	1/06 B		e, M	wn, State Iaryland
Ba	Depar Depar Impor any Ir		21. Signature of Funeral Service L Thomas Grego	Duy-		2	Name and Address Cremation 299 Frede	ss of Facility Society rick Road	Of Maryl Baltimo	and Inc re, Mar	ylan	d 21228
	Physician /Medical Examiner		Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	caused the dea each line. CUCU (or as a conse	ecc	1 . 1/	g, such as cardiac o	or respiratory arres	st,		Approximate Interval Between Onset and Death
50,	ficate be executed physician and is the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	(or as a conse							
68760,	ficate t	edicai		d								
.O. Box 6	death certif e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	itcome of pregn birth 2 Fet nant at time of nown	al death 3	Ectopic pregnancy Other (specify)			23d. Date Montil		ry Day Year
<u>a</u>	res that the igned by th be deteche		Part II. Other significant condition	ns contributing to d	leath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contrib	ute to the	e cause of death?
rds	- v -	ed by	1) euch	ā .					1 ☐ Yes	2 □ No 3	☐ Proba	ably 4 Unknown
of Vital Records,	has b	Completed	Gen	re to	Horiu	2			24a. Was an autopsy perform	ed// dea	ath?	esy findings available apletion of cause of
ital	ician: Th certificate rector, pag	Be C	25. Was case reterred to medical examiner?		7-300	7		26. Place of Death			1103	2 110
of \	ding Physician; h. After this certific funeral director,	ို	1 □ Yes 2 □ №		_	ERVOutpatier		4 Nursing no	me 5 Residen)
no	ding I h. After funer	tlon	27. Manne of Death 1	9	of Injury oth, Day Year)	28b. Time o	Worl	/at k? Yes 2 ☐ No	28d. Describe how	v injury occurred		
Division	or Attendent fler deat Director; in by the	Certification;	2 Accident investig: 3 Suicide 6 Could n 4 Homicide determine	not be 28e. Place	e of Injury - At I ling, etc. (Spec	nome, farm, str	reet, factory, office		28f. Location (Stre City or Town,	eet and Number State)	or Rural	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) Certifying Certifying	g Physician: To the Examiner: On the o and man	e best of my kn pasis or examin nner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and mann e and place, an	er as sta d due to	ited. the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier				29c. License		290	d. Date signed (Month, D	Day, Year)
)	/		()	A CHC	KME		DS:	7028		5-30	0-0	6
(i	5 Sta	te	30 Name and addless of person v A A A A A A A A A A A A A A A A A A	who completed cause of the complete of the com	An	ne A	rundel	Med	: cal	Cen	1+.	er_
A. Salar	Registr		MAY3	1 2006	live	K A	and I					

			For State Registrar	State of M	aryland /		artment of tificate of				ene g. No.2 ()	06	17027
	Physici	an	1. Decedent's Name (First, Middle, Last)						1	Date of Death Month	Day	Year	3. Time of Death
	/Medic		Frank B. Smoot							May 30,	1		4:00 A M
	Examin	er	4a. Facility Name (If not institution, give	treet and number	-)		4b. City, Town,		of Death			nty of Death	
			3214 Marnat Road 5. Social Security Number 6. Sex	7 Δ	ge (In yrs. last	hirthday)	Pikesv:		24 Hrs. 8	B. Date of Birth	Balt	imore	plene (State or Foreign
Н	Funeral Director			[M 2□F	99	Yrs.	Months Day		Min.	(Month, Day,	Year) 1906		olece (State or Foreign
			Usual Residence of Decedent						1 0	ary /,	1900	\ VITE	ginia
	how		10a. State 10b. County		10c. City, To	own or Lo	cation					1	10d. Inside City Limits
	Ba-f-	cto	MD Balti	more			Pike	esvill	.e				1 ☐ Yes 2 XNo
	or 20	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen o	of What Cour	ntry?
	s 23e	rai	3214 Marnat Road		. Free in H.C.	12.1	Mar Barrier and	212		#. Van Na	14.0	USA ace - Americ	on Indian
	item free	Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 X	?	13.1	Was Decedent of f Yes, specify Cu	ban, Mexica	n, Puerto R	ican, etc.)		lack, White,	
2	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	•		1 ☐ Yes 2 🟋 N	Specity:	:		Spec	ify: Wh-	ite
Ş	filed within 72 hours after death with the Maryland Hygiene. other then "netural", or items 23a or 28a-f ehow ent, the Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		16		ient's Usual Occi		et of working	. 1	6b. Kind of	Business/Inc	
Š	thin 7	ple	Elementary/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT use retir	ed)	St Of WORKING	'			
7	filed withing Hygiene.	ပ္ပ	12				Artist						papers
ב	a a b	Be	17. Father's Name (First, Middle, Last)		_			18. Moth	er's Name (First, Middle, N			
Maryland 21215-0036	should be ind Menta marked umatic ev	ဥ	Addison	- Dried		oot	ng Address (Stree		Mary		V	Dis	ney
<u>ā</u>	d 2 shows and 7 iem		19a. Informant's Name/Relationship (Ty) Dorothy M. Smoot,								15-6-	1011	
45	s 1 and 2 should if Health and Men item 27 is marks other treumatic		20a. Method of Disposition	wile	20b. Place	of Dispo	Marnat I sition (Name of		P1K6 Da	esville		2120 n - City or To	
2	ages of of t: if it		1 ☐ Burial 2 Tremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	θ [-	natory`or other p		OE /21	100	D 1		15
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or otl		21. Signature of Funeral Service License	e George	MacNah	h 22	ematory,	ress of Facili	ity Cror	700	Balti	more,	MD, Inc.
ñ	Dep many many many many many many many many		1 Secz E1	Ton the	riacivab		299 I	reder	ick Ro	oad Ba	ociet Itimor	y or .	MD, Inc.
			23a. Part1. Enter the disease, or compli	cations that cause	ed the death. D	o not ent						.е, ги	Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final			^							Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or a	THM i	ce of):							
	Examiner		Sequentially list conditions	CORO Due to for a	NARY	AR	TERY	0156	EASE				30 YEARS
	D =	ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s à συπέ σ ιμεπι	out).			-				
6	be exectled sician end burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
ຼິ່ງ	ate be ex hysician the burial	Ē	Todaking in dodan, Eddi	Due to (or a	s a consequenc	Ce Of):							
09/8	ate by	dicai										-	
×	eath certific ettending p for use as	Physician/Me	IF FEMALE:	3c. If yes, outcom	e of pregnancy						234 5	Date of delive	201
ROX	etter for u	clar	in the past 12 months?	1 Live birth	2 Fetal dea at time of death		Ectopic pregnan Other (specify)	су			1	Aonth	Day Year
J.	the d	Jysi	1 Yes 2 No 9 Unknown	9□ Unknown									
	law requires that the de as been signed by the e 2 should be detached f	by PI	Part II. Other significant conditions con	tributing to death	but not resulting	g in the u	nderlying cause g	iven in Part I	l.	23e. Did tob	acco use co	ntribute to th	ne cause of death?
Vital Records,	w require been sig should b	edt	PERIPHERAL V	ASCULA	2 Dise	EASE				1 🗌 Ye	s 2□No	3 Prob	ably 4 Unknown
ပ္က	aw re is bec 2 sho	plet	CONGESTIVE HEA	et FAI	-URE					24a. Was an		. Were auto	psy findings available
Ĭ	ө - д	Completed								autopsy perform	ed?	death?	mpletion of cause of
IIa	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place	e of Death (Check only one			
<u>o</u>	Physicien: r this certific ral director,	ု	1 ☐ Yes 2 😿 No	ospital: 1 🗌 Inpai			t 3 DOA	ther: 4 🗆 Nu		e 5 Resider			v)
<u></u>	ding P	Certification:	27. Man er of Death 1 V Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b ay Year)	o. Time of Injury	W			ld. Describe how	v injury occu	urred	
DIVISION		cat	2 Accident investigation 3 Suicide 6 Could not be	OO- Disease in	-1 As be	6]Yes 2□		of Logotion (Ctr			10
⋛	or At after d Direct in by	i i	4 Homicide determined		etc. (Specify)	tarm, str	eet, factory, office	•	28	City or Town,		n <i>ber or Hur</i> a	l Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funarel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	icien: To the hes	t of my knowled	loe death	occurred at the	time date ar	nd place, an	id due to the car	use(s) and n	manner as st	tated
	• Hou	edicai	(Check only 2 Medical Exeminate)	ner: On the basis and manner	of examination	and/or in	vestigation, in my	opinion, dea	ath occurred	at the time, da	te and place	e, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Lice	nse number		29	d. Date sign	ned (Month,	Day, Year)
			& A Sulla	ran M	5		Do	0631	64	м	av 30	, 2006	
	h		30. Name and address of person who co	mpleted cause of	death (Item 23a	a) (Type,	Print)						
				HARAN	550	5 Hg	PKINS	SAYV	IEN (CIRCLE	BALT	MORE	HD 21224
	Sta		31. Date filed (Month Pay Ygar) 1 20	06 32 Regis	trar's Signatur	A	me						
	Registi	ar		A CONTRACTOR OF THE PARTY OF TH		1							

			For State Registrar	State of Man		artment of F			giene Reg. No.2 0 0 6	17028	
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea	Day Year	3. Time of Death 2:45 A	
	/Medic Examin		4a. Facility Name (If not institution, girls BON SECOUNS)	ve street and number)	,	4b. City, Town, of SALTIN	or Location of Death	107177	4c County of Death		
Jan 1	Funeral Director		22014 2655	Sex 1 X M 2 □ F 7. Age (II	n yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Da)	y Year) 9. Birth Cou	plece (State or Foreign intry) yland	
	a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A		Oc. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	with the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	,	
980	J within 72 hours after death with the Maryland jiene, tiene, "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at	by Funeral	332 Stiemly Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rin U.S. 13	21060 Was Decedent of Fif Yes, specify Cub 1 Yes 2 No	dispanic Origin? (Si an, Mexican, Puent Specity:	pecify Yes or No- o Rican, etc.)	Specific	ican Indian,	
21215-0036	ed within 72 he giene. er then "netu	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retire enter	during most of work	king	16b. Kind of Business/l	•	
Maryland 2	d 2 should be filed withing and Mental Hygiene. 7 is marked other ther treumatic event, the Mental treumatic event, the Mental treumatic event.	To Be Co	17. Father's Name (First, Middle, Las Emory Snyder	()	Carp	CIICCI	18. Mother's Nam	100	Maiden Sumame)	1011	
Man	d 2 sho th and I t7 is me treums	1	19a. Informant's Name/Relationship Sherrie Steger /			ing Address (Street Stiemly A		rai Route Numbe n Burnie	r, City or Town, State, Z. MD 21060	p Code)	
a)	Pages 1 and ment of Healt ant: if Item 2 arts or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	20b. Place of Disp cemetery, cri		ce) Jur	Date 1, 2006	20c. Location - City or 1 Crownsville		
Balti	permit. Page Department of Important: if eny Injury or once.		21. Sign rure Funeral Service Lige		4	22. Name and Addre	ess of Facility	ıneral H	ome, P.A. Burnie, MD	21061	
1	Physician		23a. Part Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		death. Do not e		ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
~,09289	Medical Mescien and Mosicien	icai		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. BiLA Due to (or as a c	onsequence of): TERAZ onsequence of):	PNEU	MONIA)		
P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive Month	very Day Year	
	w requires that been signed b should be deta		Part II. Other significant conditions COSOMAN AR 5 CH 1 ZO A F F				ven in Part I.		obacco use contribute to	N	
of Vital Records,	: The law re cate has bee page 2 sho	Completed by	5CH1ZO AFF	ECTIVE	DIS OR D	ER			an 24b. Were aut prior to commed? death? 1 \(\sumeq\) Yes	opsy findings available ompletion of cause of	
Vita	ysiclan: Th is certificate director, pag	To Be	25. Was case referred to medical — examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Ott	200	th <i>(Check only o</i>	ne) dence 6 □Other (Spec	(fu)	
Division of	on of the or	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		of 28c. Inju			now injury occurred		
DIV	el or Attences after death	Sertifi	3 Suicide 6 Could not determine		- At home, farm, s Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or Rui vn, State)	ai Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifying F (Check only one) 1 Certifying F 2 Medical Exe	thysician: To the best of m miner: On the basis of ex and manner stated	amination and/or i	ath occurred at the ti nvestigation, in my	me, date and place opinion, death occu	rred at the time, o	date and place, and due	to the cause(s)	
)	with:	M	29b. Signature and title of certifier Mut V.	mombel			14949		29d. Date signed (<i>Month</i> 5 / 79 / 70	06	
	4		30. Name and address of person who JA NET V 1 M C 31. Date filed (Month, Day, Year)	completed cause of deat CHAELI	Signature -		BALTIMO	RE. 57,	BALTIMOR	E MO 2023	
	Sta Registi		MAY 3 1 2006		X Good	2					

		_ For		artment of Health and		0000 17000	~	
		= State Registrar	Cer	tificate of Death	Reg. N	Reg. No. Death 3. Time of Death		
Physicia	ın	1. Decedent's Name (First, Middle, Last) MARCARET ST	55154		Month Day Year 5 17 2006 2:57 AM			
/Medica		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Deat		4c. County of Death		
Examine	er	Manor Care - Dulaney		Towson		Baltimore		
Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)	7	
Director		199-01-8141 1 M 20 F Usual Residence of Decedent	88 Yrs.		Aug. 4, 19	17 PA		
and and		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits		
Mary F sh	to	MD Baltimore	Balti	more		1 ☐ Yes 2 ŽNo		
n the	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?		
23e cast but the	rai	8800 Old Harford Roa		21234		SA	_	
er des	Funeral	11. Marital Status 1 ☐ Never Married 12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑		Was Decedent of Hispanic Origin? (S If Yes, sp <i>eci</i> fy Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.		
be filed within 72 hours after death with the Maryland tal Hygiene. It has a second then than 'natural', or items 23e or 28e-f show event, it a Madical Examiner must be nuitified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ 3 ☑ Widowed 4 ☐ Divorced Year or Dates		1 ☐ Yes 2. No Specify:		Specify: White		
2 hou		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wo	rkina 16b.	Kind of Business/Industry		
ithin 7	Completed	Elementary/Secondary (0-12) College (1-40	life. (DO NOT us <i>e retired)</i> Pervisor	A	Bank		
led will her the her the		12th 17. Father's Name (First, Middle, Last)		-	me (First, Middle, Maid			
d be fi) Be	Andrew Parker		Mary		,		
should Me mark mark metter	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or R	-4	y or Town, State, Zip Code)		
nd 2 salth as 27 ls rrtreu		Barry Steeley / son	1070	9 Davis Ave. W	loodstock	MD 21163		
of Hear	1	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	ΙΔ	matory or other place)		Location - City or Town, State		
Page ment ent: It ury o		* 4 ☐ Donation 5 ☐ Other (Specify)	Bayvie	w Crematory 5/		altimore MD		
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Proporties if them 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other treumetic event, the Marical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	[1]	2. Name and Address of Facility 3 Connelly Funer	00 Mace A	Ave. Balto.MD of Essex 21221		
		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not ent			Approximate Interval Between		
Physician				'S DEMENTI	A	Onset and Death		
/Medical Examiner			as a consequence of):					
LAdminici	-	Sequentially list conditions, if any, leading to immediate b. Due to (or a	as a consequence of):					
led nsit	Examiner	Cause (Disease or injury	20 4 001100 4001100 017					
be executed ician and burial-transit	Exal	that initiated events c. Due to (or a	as a consequence of):					
of ou,	dicai	d						
artifica ing ph e as th	Med	IF FEMALE:			-			
The Colds, F.O. BOX of the law requires that the death certific are has been signed by the attending page 2 should be detached for use as!	hysician/Me	in the past 12 months?	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
the de ched	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Journal (speedily)				
s that	by Pt	Part II. Other significant conditions contributing to death	n but not resulting in the u	inderlying cause given in Part I.		co use contribute to the cause of death?		
w requires is been significations.	ed b				1 🗌 Yes	2 No 3 Probably 4 Monknow	1	
law re las ber	ompieted	<u></u>			24a. Was an autopsy	24b. Were autopsy findings availabl prior to completion of cause of	8	
The The page	Соп				performed 1 ☐ Yes 2 ☐		_	
VILAI icien: T certificat rector, pa	Be	25. Was case referred to medical examiner?		Other	ath (Check only one)	a Flow (0 '/)	-	
ON OF VICAL MEDINGING PROPERTY. After this certificate has funeral director, page 2	1.70	1 Pes 2 No 1 Inpa 27. Manner of Death 28a. Date of Information (Month, Month, Information)		of 28c. Injury at	Home 5 Residence 28d. Describe how in			
IOI nding th. :: Afte e fune	atlor	1 ☑Natural 5 ☐ Pending (Month, 1	Day Year) Injury	Work? M 1 □ Yes 2 □ No				
DIVISION OF VITAL To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, st , etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)		
pitel c	O	29a. Certifier 1 Certifying Physician: To the be	ast of my knowledge, deal	th occurred at the time, date and place	e and due to the cause	e(s) and manner as stated		
e Hos 24 ho e Fun etely f	edicai	(Check only one) 2 Medical Examiner: On the basis and manner	s of examination and/or in	nvestigation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(s)		
To the within To the complete	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month. Day, Year)		
		D. W cond)	2005910	+ 05	5-30-2006		
2		30. Name and address of person who completed cause of			2015-501-			
<i>y</i>				ENTER DENUE	721 >1 2145/04	NN ND 41/36		
Sta Registi			are B A	lade				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

30.14.101		1-For State Registrar State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No.	1/03
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Till	me of Death
ledical Exami	ner	ROSA ELIZABETH JCHAFFEK May 22, 2006	856 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore	4-
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace	_
Director		212-58-3422 1 M 2XF Yrs. Months Days Hours Min. DEC, 09, 1951 Foreign Countryy Usual Residence of Decedent	,
GH.			Inside City Limits
Alary Land 28a-f sliow dat once.	or	MARIJLAND NIA BALTIMORE CITY IX	Yes 2 No
ith the Mary land 23a or 28a-f sho potified at once.	Director	10f. Silver and Number 10g. Citizen of What Country?	
th the 23a or iotifie			
death with the Mary Lind or items 23a or 28a-f sh nust be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc.	idian, Black,
ter des	1	1 3 Widowed 4 M Divorced III Yes Give Year 1 Yes 2 M No encoint Consider	ענ
uss after nural", o amiucr 1	d by	15 December 5 Februaries (Specific Agents to specific to the Company of the Compa	
¥ , # 4	lete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life, DO NOT use retired)	
5-0036 Ted within Hygiene Lother than	Completed	12 **HGRADE BUS DRIVER MOTRAWS; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	TBUSCO.
215-00 be fired winted Hygier riked other	Be C		, /
2121 ould be fi Mental H marked	To B	19a. Informant's Name/ill lationship (Type, Print) MANUEL ELIZABETH TRO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip of	ode)
Baltimore, MD 21215-0036 pennir Pages I and 2 should be fi'ed within 22 beanment of Health and Menual lygicine Important: If item 27 is marked other than "ligury or other traumatic event, the Medical injury or other traumatic event, the Medical		CHARLES MANUEL MARCUS PAYNE BROKON) 2452 FRANCIS ST. BALTIHORE, MO. 21	217
ore, ME s Land 2 s of Health a If item 27 ner traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State (Crematory or other place) 20c. Location - City or Town,	State
C" C D = -		4 Donation 5 Other Specify: MT. ZION CEMETERY 15-30-06 / ANSONIVAL	F MA
Baltimo		21. Signature of Funeral Service Licensee 22. Name and Address of Fallity BROWN TR. FUNERAL	HOME
		DIENIET 10. WILLIAM 3140 N. FULTON AVE. BALTO, MD. a	21217
Prysician Medical		failure. List only one cause on each line.	proximate Interval tween Onset and Death
Txaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):	Deam
		Sequentially list conditions, b.	
	iner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.	
- 14-	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
and - trans			
760, cate be ex physician he burial	Medical	□ AMENDED □ tem#23a,PII,27,perME,g856,6/7/06 TT	
	-	123h Was decedent pregnant in the	Year
ox 68 cath certifi	sician	past 12 montris? 4 Pregnant at time of death 5 Other (Specify)	
AN = 2	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I.	
P.O. Es that the consumer that the consumer to	by	Livror Cimphonia	
cts, equire equire outd b	eted	24a. Was an 24b. Were autopsyl	
COT e law 1 e has b	Completed	autopsy prior to complet performed? death?	tion of cause of
Division of Vital Records, rat or Attending Physician: The law requires after death at Director: After this certificate has been seed in by the funeral director; page 2 should	e Co	26 Mag appa referred to medical	2 No
Vita ysicia his cel	o Be	examiner? Hospital: Destruction Destru	e
of ing Pl	n: T	27 Manner of Dooth 290 Date of Injury 200 Time of Injury 1990 Inju	
Sion trend death ctor: y the f	atio	A Natural 5 Pending 1 Yes 2 No large	
Divisio pital or Atten ours after death teral Directors	Certification:	3 Suicide 6 Could not be determined (Specific) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Round or Town, State)	ute Number, City
ospit: hours unera			
Division of Vital In the Hospital or Attending Physician: within 34 hours after death. To the Funeral Director: After this centificompletely filled in by the funeral director.	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause	e(s)
MAT NO TO	Me	and manner stated 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Da	ay, Year)
		O.C.M.E. May 22, 2006	
		30. Name and address of person who completed cause of death (Item 23a)	
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
· 網羅 編起 珠 河	tate trar	Manager Manage	

			For State Registrar	State of Marylar		nt of Health and I te of Death	Mental Hygie Reg.	L 0 0 0	17031
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		LAWREN	CE /	SNAIR		MAY 2	7,2006	9,00 M
	Examin	er	4a. Facility Name (If not institution, give str	reet and number)	4b. Cit	y, Town, or Location of Death		4c. County of Death	11:42 00
	Euroval		5. Social Security Number 6. Sex	7. Age (In yrs.		er 1 Year If Under 24 Ars.	8. Date of Birth	9. Birthi	place (State or Foreign
L	Funeral Director		218-28-6445 1181	120F 73	Yrs. Month:	Days Hours Min.	Month, Day, Ye	ar) Cou	MD.
	pg .		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Location		7 //2		10d. Inside City Limits
	Maryla f aho	20	MD BALT	MERCE L	LAIRTH	PDF			1 Yes 2 □ No
	r 28s-	rect	10e. Street and Number	riore	101. 2	ip Code	10g.	Citizen of What Cou	ntry?
	death with the Maryland ime 23a or 28a-f ahow r numbe notified at	alD	1715 SUMMI	T AVE.		21227		U.5.A	•
	teme	Funeral Director		2. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
39	72 hours after natural', or ite	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 DYes 2 No / 9 tf Yes, Give Year or Dates: / 9	74 1□Yes	20 No Specify:		Specify: 12	HITE
21215-0036	72 hou	Completed	15. Decedent's Educa (Specify only highest grade		16a. Decedent's Us	ual Occupation vork done during most of wor	ting 16b	. Kind of Business/In	dustry
21	within 7 ene. then "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	\mu_g	0-1:0	~ X
	Hygier Hygier ther ti	Co	17. Father's Name (First, Middle, Last)		ריין.	12 TARY	ne (First, Middle, Maid	RETIRE	=0
au	id be i ental ked o	To Be		SNAIR	SD.	LF	NO OTA	OKB	
Maryland	ges 1 end 2 should be filed within 72 hours after death with the Marylan at of Heelth and Mental Hygiene. If it item 27 is marked other than "natural", or liteme 23a or 28a-1 ahow or other traumatic avent, the Modical Examiner mant be notified at		19a. Informant's Name/Relationship (Type			ss (Street and Number or Ru	ral Route Number, Ci	ity or Town, State, Zij	Code) 21221
	end 2 eelth m 27 i	9	ERICA. SNAI	R	17150	UMMIT AU	E. HAL	ETHROPE	= MD.
lore	Peges 1 nent of H int: If ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	1 .	Place of Disposition (N cemetery, crematory of	other place)	Date 1 200	. Location - Clay or To	own, State
Baltimore			4 Donation 5 Other (Specify) 21. Synature Foreral Service Licensee		A 22 Name	and Address of Facility	2006	H.H. CO	37 14.0
8	permit. Departr Importu any inji		Homas .	Skark	2 SK	IRDA F.H.	BALTO	· MD-	21224
			23a. Part1. Enter the disease, promplications, or heart failure. List only one	ations that caused the dea	th. Do not enter the m	ode of dying, such as cardiac	or respiratory arrest,	1	Approximate Interval Between
ä	Physician		Immediate Cause (Final disease or condition	ASE		Onset and Death			
1	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	\			le v (Karner a
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):	Ť		-	an yell
$\sqrt{}$	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	SYSTEMI	c Hypes	STENSION			30 UPARS
000	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
8760,	physic the p	dicai	d.						
Box 6	death certific e ettending p id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregn				23d. Date of deliv	erv
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown				Month	Day Year
P.0	thet the de ted by the detached	Physician/Me	9 Unknown						
ds,	8 5 8	à	Part II. Other significant conditions control PAR I PHERA) A	ARTERIA)	sutting in the underlying	cause given in Part I.	1 ☐ Yes	co use contribute to t 2∭No 3 ☐ Prol	he cause of death?
COL	w requir been si should	letec	DEDDECCION	1	PISH		24a. Was an		opsy findings available
Division of Vital Records,	The lav	Completed	PERIODS	V		-	autopsy performed	1? prior to co	impletion of cause of
ita		BeC	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes 2 ⊠ ath Check only one	No 1 ☐ Yes	2 NO
> <	d is	၉	1 ☐ Yes 2 🗷 No		ER/Outpatient 3		lome 5 Residence	e 6 ⊡Other (Specia	(y)
no	on of the contract of the cont	tlon:	27. Manner of Death 1 Naturat 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
<u>Visi</u>	Attending r death. ector: Alter by the funer	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, fact		28f. Location (Stree	t and Number or Run	al Route Number,
Ö	rs efte al Dir	Certification:	4 Homicide	building, etc. (Speci	rty)		City or Town, S	tate)	
	Hospital of Pours of Funeral Distributed in Italia di It		(Check only 2 Medical Examine	er: On the basis of examin.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	, and due to the caus irred at the time, date	e(s) and manner as s and place, and due t	stated.
	To the Hospital or Atlandi within 24 hours effer death To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and tille of certifier	and manner stated.		9c. License number		Date signed (Month,	
	⊢ ≯ ⊢ ŏ		gnotten Sall	len mo			041711 M	AV 20	2001-
	intl		30. Name and address of person who con	CARDIO LA		MARYLAND DO	וין וווודט	111 00,	2006
	10		JONATHAN SAFR		+49 WILKE	NS AVENUE S	UITE 300 F	BALTIMORE, M	MPYLAND 21229
	Sta Registi		31. Date filed (Month, Day, Year) MAY 3 1 2006	Registrar's Sign	ature			,	

			State of Maryland / [State Registrar Amend Item #23a Per Phy G8					giene Reg. No. 200	5 17032
			1. Decedent's Name (First, Middle, Last)	700	JH	2. Date of Dea	ath	3. Time of Death	
	Physicia		Henry Raymond Sulkowski	Month 05	21 2006	2300 hrs⁴			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. Cit	y, Town, o	Location of Death		4c. County of Dea	
			Harford Memorial Hospital			e Grace		Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Yrs. If Und Month	er 1 Year S Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h 9. Bir y, Year) Co	thplace (State or Foreign
	Director		195-18-8700 15 86 Usual Residence of Decedent				Jan. 2	6, 1920 Per	nsylvania
	yland Now		10a. State 10b. County 10c. City, Tow						10d. Inside City Limits
	Mar.	ţ	Maryland Harford Bel Ai	ir 					1 ☐ Yes 2 X No
\circ	or 28	Funeral Director	10e. Street and Number		Zip Code			10g. Citizen of What Co	ountry?
30	ath w	rail	224 Rolling Knoll Road		21014			USA	
36	er de	nue	11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 ▼ Yes 2 □ No	13. Was Dec	pecify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	- 14. Race - Ame Black, Whit	
38	ours after death with the Marylar ral', or Iteme 23a or 28a-1 ehow Exarcit at must be notified at	by F	1 Never Married Married 1 Never Married 2 No 1 No	1 ☐ Yes	2 X No	Specify:		Specify: Wh	ite
~ P	within 72 hours after death with the Maryland ene then "natural", or Iteme 23a or 28a-f show he Medical Esandrer must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Us	sual Occup	ation during most of work	ina	16b. Kind of Business	/Industry
215	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT	use retired	1)	,,,,g		
7	led w lygier her th	ပိ	17. Father's Name (First, Middle, Last)	Ingineer	<u> </u>	18 Mother's Nam	First Middle	Chemical C	ompany
arphiMaryland 21215-0036	ntal H	Be c	Eugene (nmn) Sulkowski					aranowska	
Σ	should nd Me mark mark	ဥ		b. Mailing Addre	iss (Street		-	ar, City or Town, State,	Zip Code)
	nd 2 salth ar 27 is r trau		Sandra Gilbert/ daughter 31	10 Barcl	ay Co	ourt, Abi	ngdon, 1	MD 21009	
ie o	of Hear		20a. Method of Disposition 20b. Place of cemeter comments	of Disposition (A	lame of r other plac	ce) !	Date	20c. Location - City or	Town, State
0 E	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ Hillto			orp. 5-24		Towson, Ma	
21/06 Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natureny injury or other traumatic event, the Medical ODGS.		21. Signatura at Fune at Service Licensee					uneral Home ngdon, Mary	
151			23a. Part1. Enter the disease, or complications that caus id the death. Do shock, or hard failure. List only one cause on each line.	not enter the m	ode of dyir	ng, such as cardiac ration	or respiratory ai	rrest,	Approximate Interval Between
	Physician		disease or condition	J/Res	DIR	TORY /	TRRES	+	Onset and Death
\mathbf{I}	/Medical Examiner		Due to/(or as a consequence		Shoo	-11			
	*	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):				.	
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittated events	BSTRUC	TIVE	Pulmo	NARY	DISCASE	
20	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence	of):					
EN/ 8760	cate be ohysicie the bur	dicai	Chronic F	HEART	14	ILURE			
T ×	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy					23d. Date of de	livon
Bo	The law requires that the death certifica are has been signed by the ettending pr page 2 should be detached for use as t	Physician/Med	in the past 12 months? 1 Ves 2 No.	h 3 Ectopic 5 Other		/		Month	Day Year
7. O. 9	t the c by the	hysi	9 Unknown						
	s tha gned	by P	Part II. Other significant conditions contributing to death but not resulting		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
000	equir sen si ould I	ted	DITATERAL PIEURAL ET	-L Pleural Ettusion					robably 4 Unknown
/ /-	a law I	Completed					24a. Was autop	osy prior to	utopsy findings available completion of cause of
13 1	: The						1 Yes		2 X No
×) X	sician certifi rector	Be	25. Was case referred to medical examiner?		Ctt	26. Place of Deal			
of	Physic representation of the properties of the p	5		. Time of	28c. Inju	4 🗀 Nursing no		dence 6 Other (Spe how injury occurred	icity)
ion	Attending Physician: r death. sctor: Atter this certifici y the funeral director.	ation	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury M		rk? Yes 2 □No			
$S_{U}/\mathcal{K}^{\mathcal{O}}\mathcal{U}$ Division of Vital Records.	r Atts ter des irecto	rific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	farm, street, fact	ory, office		28f. Location (S City or Tox	Street and Number or R wn, State)	ural Route Number,
٥	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attent this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 12 Certifying Physician: To the best of my knowledge	ge, death occurr	ed at the to	me, date and place,	and due to the	cause(s) and manner a	s stated.
0	the Ho Ihin 24 the Fu mpletel	Medic	(Check only one) 2 ☐ Medical Examiner: On the basis of examination at and manner stated. 29b. Signature and title of certifier		on, in my o			date and place, and du 29d. Date signed (Mon	
•	F 3 F 8) WEKN	~, mp				05/22/0 RACE, MO	**
	101		30. Name and address of person who completed cause of death (Item 23a) KARTIK DESAI, Mb. 501 S.L.		AVE	HAVY	e de 6	RACE. MO	21078
	St		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Regist	rar	MAY 3 1 2006 Benever It	Special	1				

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item #9 Per FH G*55 5/3/11/10/61/6/Hbf Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Bobby Ray Sinclair May 24, 2006 12:39 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 212 S. Penn Street Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F Months Yrs. February 06, 1952 Balting Director 214-54-5128 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1∏Yes 2□No the Medical Examiner must be notified at Director NA **Baltimore** M.D. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 or items 23a 21201 212 S. Penn Street Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Marned 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Heelth and Mental Hygien
Important: If Itam 27 is marked other th
any injury or other traumatic event 12 Administration Maryland State Lottery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shirley M. Rozier Johnie F. Sinclair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 S.Culver Street Baltimore, Md 21229 Shirley Jean Douglass/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 05-27-06 Catonsville Md 21. Signature of Funeral Service Licen 22. Name and Address of Facility Vones erla Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 0 /Medical Examiner Ankey (oronary Sequentially list conditions. Due to (ur as a con equence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the ettending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? renal 1 Yes 2 No 3 Probably 4 Unknown Chronic Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 ☐ Yes a Hospital or Attanding Physician: 24 hours after deeth. a Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1743386 5-26.06 Cecun 457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place, Bulhinore ws 21217 R. 1 toward 1714 ELHW 31. Date filed (Month, Day, Year) MAY 3 1 2006 22. Registrar's Signature State Registrar

			For State Registrar	State of N	/larylan		artment of F			giene Reg. No. 2006	17034
	Physici /Medi		1. Decedent's Name (First, Middle Richard T. Samuel	, Last)					2. Date of De.	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution	give street and number			4b. City, Town, o	Location of Dea		4c. County of Death	n
	Funeral Director		5. Social Security Number 217–30–1736			last birthday Yrs.	Months Days	If Under 24 Hr. Hours Mir		th 9. Birth (Co.), 1963 Mary	nplace (State or Foreign untry) 1and
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation				10d. Inside City Limits
2	ith the Marylar or 28a-f show	ctor	Maryland NA		Ba	ltimore					1 ⊈Yes 2 □ No
Richan	vith the	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	untry?
5	eath v	eral	2624 Park Heights To	errace 12. Was Deceder	nt Ever in U	.S. 13.	21215 Was Decedent of H	lispanic Origin? (Specify Yes or No	USA 14. Race - Ame	ncan Indian.
2	1215-0036 within 72 hours after death with the Maryland ene. ene. https://www.natural.com/lema.23a.or.28e-f.ahow.htm.Medical Examiner must be notified at	by Funeral Director	1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	s? No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	nto Rican, etc.)	Black, White	e, etc.
_	21215-0036 d within 72 hours af giene. er than "natural", or the Medical Exam	eted	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usual Occup	during most of we	orking	16b. Kind of Business/	ndustry
9	within within then	dmo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use retired nanic	3)		Jiffy Lube	
		To Be Completed	17. Father's Name (First, Middle, Edward B. Samuel	Last)				18. Mother's Na Loris Le		. Maiden Sumame)	
	y, Maryland and 2 should be file ealth and Mental Hy m 27 is marked oth her traumatic avant		19a. Informant's Name/Relationsl Linda Samuel Nelson	nip (Type, Print) sister		1				er, City or Town, State, 2 , Maryland 212	
			20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (S)			emetery, cre	osition (Name of matory or other place orial Park	Cem. June	Date 1, 2006	20c. Location - City or Baltimore, Ma	
	Baltimo permit. Page Department of important: if any injury or anges.		21. Signature of Funeral Service	icensee					•	al Home P.A. Maryland 2121	7
•	Physician /Medical Examiner physicien and physicien and physicien and the prital-transit	dical Examiner	23a. Pant. Enfer the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. MetA Due to (or a c. Due to (or a d.	as a conseques as a consequence	uence of):				g CANCER	Approximate Interval Between Onset and Death
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	death 3	□Ectopic pregnancy □ Other (specify) _			23d. Date of deli Month	very Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEEP VEIN Thrombosis							23e. Did tobacco use contribute to the cause of				
	Reco	omplet								an 24b. Were au prior to death? 2 No 1 Pres	topsy findings available completion of cause of
	/ital	Be	25. Was case referred to medical examiner?	I I itali		-	100		eath (Check only o	(-	
	Of \Physical Christon of the control	5	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In (Month, I		ER/Outpatie		4 🔲 Nursing		dence 6 Other (Spec	ufy)
	Division I or Attending after death. Director: After	Certification:	↑ Natural 5 Pendin 2 Accident investit 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of		Injury ome, farm, s (y)	of 28c. Injur Wor 1 reet, factory, office	k? Yes 2 □ No	28t. Location (5 City or Tov	Street and Number or Ru wn, State)	ral Route Number,
	ne Hospita 124 hours In Funeral	Medical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the be Examiner: On the basis and manner	of examina	wledge, dea ation and/or i	th occurred at the timestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th withir To th comp	M	29b. Signature and title of certific	01	ciAn		29c. Licens			29d. Date signed (Monti	
	,		moas	LVAZO	CITI	3	1700	5455	8	MAY 27 Ave Balt	2006
	3		30. Name and address of person	who completed cause o	r death (Iter	n 23a) (Type) 2401	W. Bel	vedere	Ave Balt	more mn
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY **Physician** 29^{bay} 2006 12:30p^M DANIEL MICHAEL SMITHWICK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4800 HYDES RD HYDES BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/15/1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**⊠**M 2□ F Yrs. 77 MARYLAND 215-32-2211 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No MD BALTIMORE HYDES Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21082 4800 HYDES RD USA deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HORSE TRAINER HORSE TRAINER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of ALFRED J. SMITHWICK EMMA WARNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t if item 27 MRS. D.M. SMITHWICK(WIFE) 22868 SUNNYBANK LN. MIDDLEBURG, VA. 20117. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. GREEN MOUNT CREMATORY05/31/06 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HENRY W. JENKINS & SONS C 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner Uspration Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine burial-transit or Attending Physician: The law requires thet the death certificate be executed Due to (or as conseque ce of): Frears attending physicien and for use as the burial-trar that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural
2 Accident s effer de.

I Director: Alter hv the fir 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours of To the Funeral I completely filled 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5200 EASTERN AVE. 7th FL. BALTO., MD. CRYSTAL SIMPSON M.D. 32. Registrar' Signatura 31. Date filed (Month, Day, Year) State MAY 3 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical Sandra L. Setters 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ORIEN KIUERSIDE FIRA If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 28F Director 70 279-32-2169 Usual Residence of Decedent 03/04/1936 DН 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Fages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "neturel", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once. 1 Yes 2 No Director Harford Belcamp MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21017 United States Funeral 1319 Lobelia Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2540 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕶 0 Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Nursing Home Elementary/Secondary (0-12) College (1-4or 5+) Cook 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Glenna Callahan Howard Semones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1319 Lobelia Lane Belcamp, MD 21017 Ms. Rebecca Setters/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 30 4 ☐ Donation 5 ☐ Other (Specify) 2006 Beltsville, Maryland Chesapeake Crematory Inc. 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives Paltimore, Maryland 21286 Approximate Interval Between Onset and Death 8717 Green Pastures Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ρ in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Cther (specify) 4☐Pregnant at time of death o detached 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier death (Item 23a) (Type, Print)

State Registrar 31. Date

32 Registrar's Signature

2006

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06-03605 Darnell Spearman

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The proposed of the proposed o	as t	ysician/A	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fregnant at time of death 5 (ancy	Month	Day Year
29b Signature and title of certifiar O.C.M.E. May 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, P.O. E res that the c signed by the be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			
29b Signature and title of certifiar O.C.M.E. May 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Records The law requirate has been page 2 should	omplete			autops perform	y prior to ned? death?	completion of cause of
29b Signature and title of certifiar O.C.M.E. May 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	cian:		evaminer?	Other:		Pacidonae 6 1 Othe	as Saana
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Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	F 3 F 8	Me					onth, Day, Year)
MAN A TORREST AND ASSESSMENT			Carol Allan, MD Assistant Medical Examiner 111 Penr	Street, Baltimore, MD 2120)1		
				<i>u</i>			

06-03647	` b			n Black Indelible I			
Ronald Anthony S	1	man State of Maryland / [- For State legistrar	Certificate			Reg. No. 200	6 1704
Physicia Medical Examin	n/	Decedent's Name (First, Middle, Last)			2. Date of De Month May 29, 2	Dav Year	3. Time of Death 0807 hrs
E M		Ronald A. Sherman 4a Facility Name (if not institution, give street and number)		4b. City, Town, or Location of		4c. County of Death	
Funeral		1705 Clarkson Street 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday)	Baitimore If Under 1 Year If Under	er 24Hrs. 8 Date of B	N/A irth(MM/DD/YYYY) 9 Birl	hplace (State or
Director		212-42-6703	62 ,	Months Days Hours	Min. 3/9/	44 Foreig	n untry) KY
any			c. City, Town or Lo				10d Inside City Limits
≥	į Į	MD N/A	Baltimo			10g. Citizen of What Cour	1 Xyes 2 No
1 the Mary 3a or 28a	E.	10e. Street and Number 1705 Clarkson Street		10f, Zip Code 21230		USA	iu y ?
eath with items 2 is the n	Funeral	11 Marital Status 1 Never Married 2 Married 2 Armed Forces? 1 X Yes 2		Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican		o- 14 Race - Ameri White, etc.	can Indian, Błack,
after de ral", or	교	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	Unk. 1	Yes 2 XXNo specify:	lind of word damp	Specify.	White
72 hours	eted	15 Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during	dent's Usual Occupation (Give most of working life. DO NOT	use retired)	16b. Kind of Business/l	,
0036 within giene her than	Completed	10 0		Painte L18 Mother	's Name (First, Middle,		inting
215- be filed mtal Hyg rked of	8	Ashland Sherman			Clara P. Br	rumfield	
MD 21 2 should th and Me 27 is ma umarie ev	욘	19a Informant's Name/Relationship (Type, Print) Debroah J. Smith / Sister		North Ruths F			Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatie event, the Medical Examiner must be notified at once.		20a Method of Disposition 1 Burial 2 **Cremation 3 Removal from State		cosition (Name of cemetery, other place) Crematory	Date 6/2/2006	20c Location - City or Baltimore M	
Baltimo permit Page Department o Important: injury or oth	İ	4 Donation 5 Other Specify 2 Signature of Euneral Service Licensee Victor P.	Doda J	2. Name and Address of Facility Charles L. St 1501 E. Fort		ral Home, I	nc 1230
Physician		23a Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	e death Do not ente	er the mode of dying, such as c	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1			erotic cardiovascu	lar disease		Death
1		Sequentially list conditions, b					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				. <u>.</u>	
n P E	= L	events resulting in death) Last Due to (or as a consequence of death)					
O, be exected sisterian a burial - 1	edica		2010	erME,G856,61206 TI	1	I a a a a a a a a a a a a a a a a a a a	
of Vital Records, P.O. Box 68760, mg Physician: The law requires that the death certificate be exe. After this certificate has been signed by the attending physician is tuneral director, page 2 should be detached for use as the burial.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth	2	Fetal death 3 Ectopia	c pregnancy	23d Date of delivery Month	Day Year
Box death c he atten d for us	ysic	1 Yes 2 No 9 Unknown 9 Unknown	ne or deatri 5	Other (Specify)			
that the	by Pt	Part II. Other significant conditions contributing to death be	out not resulting in th	ne undertying cause given in Pa		tobacco use contribute to es 2 No 3 Prob	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rastfer death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	eted				24a Was	s an 24b. Were au	topsy findings available completion of cause of
Recol	Completed					ormed? death?	,
ital Fician: Secretific	Be	25. Was case referred to medical examiner? Hospital: Inpatient	2 ER/Outpati	26 Place of Death ent 3 DOA Other ₄	(Check only one) Nursing Home 5	Residence 6 🗸 Other	- Sagna
of Ving Phys	۲	27. Manner of Death 28a. Date of Injury (Month Day Yea				how injury occurred	
Sion Attendin death ector: A	catio	Natural 5 Pending Accident Investigation		1 Yes 2		(Street and Number or Ru	ral Pauto Number City
Divi	Certification:	Suicide Could not be determined (Specify)	y - Actionie, laint, S	treet, factory, office building, e	or Town,		.c. route Humber, Ony
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the deatt within 24 hours after death To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for	Medical C	29a Certifier (Check only one) 1 Certifying Physician: To the best of my leading to the basis of examination and manage stated.					
To win	Me	29b. Signature and title of certifier		29c License number		29d Date signed (Mor	nth, Day, Year)
67		Theodore M. King ans	<i>Q</i>	O.C.M.E.		May 29, 2006	
1860.		30 Name and address of person who complete course of dear Theodore King MD. Assistant Medical Ex		Penn Street, Baltimore,	MD 21201		

31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Marylai	nd / Depa	artment	of Health a		ental Hygi	-	16	17041
в	Physic	ian	Decedent's Name (First, Middle, Last)	Jean Marie	Sullivo	n		1	2. Date of Death Month		Year	3. Time of Death
	/Medi	cal	As Facility Name (III and III						MAY	26 6	2006	16:43 PM
	Exami	ner	4a. Facility Name (If not institution, give s SALNT AGNES	,		46. City, 1	own, or Location of ALTIA	-	F	4c. County o		
	Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1	Year If Under 2		B. Date of Birth (Month, Day,		/A 9. Birthpla	ace (State or Foreign
	Director		133 20 5857 ¹	M 25xF 76	Yrs.	Months	Days Hours		(Month, Day, Oct. 25.	1929	Count	York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ncation						d. Inside City Limits
	Manyl f sho	ō	Maryland Baltimor		Catons							1 ☐ Yes 2 ☑ No
	r 28a	rec	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of W	hat Count	ry?
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Madical Examinar must be notified at	Funeral Directo	719 Maiden Choi	ce Lane			21228			U.S.		
	tems from	nuer		Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decede f Yes, specif	nt of Hispanic Orig y Cuban, Mexican,	in? (Spec Puerto Ri	fy Yes or No- can, etc.)	14. Race Black	· America	
36	rs afte	y F	1 → Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:		1□Yes 2				Specify:		
21215-0036	2 hou	Completed by	15. Decedent's Educ	ation	16a. Deced	dent's Usual	Occupation		1	6b. Kind of Bus		
215	Pin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use	done during most retired)	of working				,
	be filed within 72 hours after death with the Marylan stal Hygiene. Ind other then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event, the Mudical Examirum must be notified as	Co		2 years	Secr	etary						ernment
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	Be	17. Father's Name (First, Middle, Last) Arthur	Sullivan					First, Middle, M Foley	aiden Sumame)	
Ž	2 should be is and Mental its marked or sumatic ever	၉	19a. Informant's Name/Relationship (Typ		19h Mailin	na Address /	Street and Number			City of Town C	to to 7i- /	2-4-1
	12 E G		Susan Shelton / n			FM 903			le, Texa			/0 0 9/
ore,	ges 1 ar t of Hea if item or othe		20a. Method of Disposition	206. 1	Place of Dispo cemetery, cren	sition (Name	of er place)	Dat	e 2	Oc. Location - C	ity or Tow	n, State
Ë	Pages ment of tant: If it jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Ba	yview (1	/30/2	2006 E	altimor	e, M	aryland
Baltimore,	permit. Pages Department of Important: If it eny Injury or c once.		21. Signa in Funer I Service License	9			Address of Facility		ice Fune	ral Ser	vice	, P.A.
	40204		23a. Part1. Enter the disease, or complic	ations that caused the dear								and 21225
	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	IAIMO		JE UMC					Approximate nterval Between Donset and Death
	Examiner		Sequentially list conditions		CHIE	CTA	SIS				5	YEARS
201	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	juence of):							
6	s be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	luence of):							
8760,	ite be ex iysician ne buria	icai	L.		,001,00 0.7.						4	
89	g phys g sthe	8	d.									
Box	eath certific attending p	an/N	230. Was decedent pregnant	c. If yes, outcome of pregna 1⊡Live birth 2 ☐ Feta		Ectopic preg	nancy			23d. Date		
O. E.	tha death certificate be executed y the attending physician and ched for use as the burial transit	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐Pregnant at time of d 9☐Unknown		Other (spec				Month	h D	ay Year
Δ.	res that tha de signed by the a be detached t		Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	idechijaa cau	se amon in Part !		23a Did taba	and the entitle		cause of death?
Records,	law requires that as been signed b 2 should be deta	d by	•		and an and an	idonying dad	so given in r ait i.				Probab	N. are
Ö	w requir	Completed							24a. Was an			
æ	he his	E						_	autopsy performe	pric dea	ath?	y findings available detion of cause of
ital	ician: T certifical rector, p	BeC	25. Was case referred to medical examiner?		-		26. Place of	of Death (C	1 ☐ Yes 2/2 Check only one	5N0 1L	Yes	No
<u>5</u>	hys this al dii	၉	1 ☐ Yes a No		ER/Outpatient	3□ DOA	Other: 4 Nurs	sing Home	5 Residen	ce 6 □Other	(Specify)	
E E	E E	ion:	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		d. Describe how	injury occurred		
Division of Vital	Attended death ctor:	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm stre	M et factory o	1 ☐ Yes 2 ☐ No		Location (Stre	at and Number	or Pum I S	Pouto Mumber
Ö	al or / s after id Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)	ot, lactory, o	11106	201	City or Town,	State)	or nurair	ioule Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completaly filled in by the fune	Medicai (29a. Certifier (Chack only one) Certifying Physical Certification Physical Cer	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at testigation, in	he time, date and my opinion, death	plane and occurred	die to the coun at the time, date	ea(ii) and mann and place, and	er de etat. I due to th	e cause(s)
	Tot Com	Σ	29b. Signature and title of certifier	lies MD		1	icense number	^	!	. Date signed (i		*
	5		Dalar 3.1				P 1860)6		MAY :	26,8	2006
_	12		30. Name and address person who com	va 900 (23a) (Type, F	Print)	ENUE	, BA			110	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 3 1 2006	32. Registrar's Signa	ture							

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	Physici		Decedent's Name (First, Middle, Last) Mv	chajlo Sr	no1ak			2. Date of Death Month May 2	Day Year 5 2006	3. Time of Death 9:15 P. M
ر د	/Medio Examin		4a. Facility Name (If not institution, give street and			4b. City, Town, or	Location of Death		4c. County of Death	
ı			1519 Filbert Street				imore		N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea Sept. 19,	9. Birth Cou 1926 Ukr	place (State or Foreign ntry) aine
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	Maryli f eho	Į	Maryland N/A		altimo					1 X Yes 2 □ No
	h the	Directo	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Cou	ntry?
	23a c		1519 Filbert Street			212			U.S.	
5-0036	hours after death with the Maryland turel, or Itama 23a or 28a-f ehow at Exeminar must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Y	Decedent Ever in U.S d Forces? es 2 📆 No , Give or Dates:	S. 13.	Was Decedent of Hi If Yes, specify Cuba 1□ Yes 2½ No	spanic Origin? (Specin, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
S S	72	eted	15. Decedent's Education (Specify only highest grade complete	red)	16a. Dece	dent's Usual Occupa	ation during most of working	16b.	Kind of Business/Ir	dustry
7	within ane. then	Completed		ge (1-4or 5+)	life.	DO NOT use retired, nanic)		Food	
מ	Hyg Hyg other		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maid		
Maryland	lental lental rked c	To Be	Mychajlo S	molak			Rose	(unkno	wn)	
ar	s 1 and 2 should f Health and Men item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street a	and Number or Rural I	Route Number, City	or Town, State, Zij	Code)
_	s 1 and if Health item 27 other tr		Martha Etheridge / Da		the same of the sa	Fox Hound			e, Maryla	
פֿב	Pages 1 nent of H int: if ite iry or ot	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal for	UIII GLALO		nsition (Name of matory or other place			Location - City or To	
Baltimore,	permit. Pages Department of Important: If If any njury or c		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	St.		AEL UKTALI 2. Name and Addres	nian 5/31/2		ltimore, l al Servic	
ñ	Dep Imp		1 REDIZ	1			ie Highway			land 21225
	Physician		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	at caused the death on each line.	. Do not en	er the mode of dying		respiratory arrest,		Approximate Interval Between Onset and Death 2 Month's
	/Medical Examiner	Iner	Sequentially list conditions b.	to (or as a consequence of the SMC) to (or as a consequence of the con	ence of):		ncer R			8 months
,00,	icate be executed physician and s the burial-transit	al Examiner	that initiated events	to (or as a consequ	ence of):					
09/89		edical	a.							
C. Box	at the death certifi by the attending tached for use as	Physician/M	in the past 12 months?	outcome of pregnar ve birth 2 Petal regnant at time of de nknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ds, F.	es thi	þ	Part II. Other significant conditions contributing	to death but not resu	lting in the u	nderlying cause give	on in Part I.	23e. Did tobacco	use contribute to the	he cause of death?
ecords,	w requir s been si should	iete		-				24a. Was an	24b. Were auto	psy findings available
r		Completed						autopsy performed? 1□ Yes 2☑	prior to co death?	mpletion of cause of
VItal	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ E	D/Out-ation	nt 3□ DOA Othe	26. Place of Death			
0	g Phys er this ieral di	n: To	27. Manner of Death 28a. D		28b. Time o	1 3 DOX	4 Nursing rione	d. Describe how in	6 □Other (Specification occurred)	/)
	Attending P death. ctor: After y the funera	atio	2 Accident investigation	Month, Day Fear)	Injury		? ′es 2 □ No			
DIVISION	al or Attending Physician: after death. I Director: After this certific d in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At hor uilding, etc. (Specify)	me, farm, st	eet, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and r	the best of my know se basis of examination	/ledge, deat on and/or in	n occurred at the tim vestigation, in my op	e, date and place, and inion, death occurred	d due to the cause(at the time, date a	s) and manner as s nd place, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License	number	29d. D	ate signed (Month,	Day, Year)
	10		· Colven Cla	ilgn1)	Do	(49)	Ma	ig 26,	2006
	,		30. Name and address of person who completed	ter !	4710		gton A	10, Pa	ilto, M	2006
¥.	Sta Registr		31. Date filed (Month, Day, Year) 3 MAY 3 1 2006	2. Registrar's Signatu	book	,				

06-03632 Scott Shiflett

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	1- For State Registrar		Certific	cate of	Death	_		Reg. No.	40	00 1104
Physician/ Medical Examine	1. Decedent's Name (First, Middl		Scott Timothy Shiflett						Year	3. Time of Death 1640 hrs
	4a. Facility Name (if not institutio Harbor Hospital	n, give street and number	r)	41	Baltimore Ci		eath	4c.	County of De	
Funeral Director	5. Social Security Nysyle 229 43 3380	6. Sex 7. A	ge (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days		Mun	6 Birth (MM/E	Fo	Birthplace (State or reign Country) Virginia
nd how any re-	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arunde1	10c. City, Town	n or Location			-	=		10d Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show any iffied at once. Director	10e. Street and Number 5302 Wasena		<u> </u>		10f. Zip Code 2122	25			en of What C	ountry?
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Montal Hygiene teath and Montal Hygiene teat 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 DIV	12. Was Deceder Armed Forces 1 Yes 2 proced If Yes, Give Year or Dates:		If Ye	Decedent of Hisps, specify Cuban,	Mexican, Pue			White, etc	nerican Indian, Black, c. √hite
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by 1	15. Decedent's Education (Special Elementary/Secondary (0-12)		5+)		s Usual Occupati st of working life. Cook				ind of Busine Restau	ss/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Her	man Shiflet				Man	ame (First, Midd rgaret	Shif1e	ett	
and 2 should ealth and Me tem 27 is me traumatic er To	19a. Informant's Name/Relations Margaret Shifl 20a Method of Disposition		r 5	5302 V	Address (Street Vasena A ion (Name of cem	venue		more,	Maryla	and 21225
Baltimore, permit Pages I an Department of He, Important: If ite injury or other tr	1 Burial 2 X Cremation 4 Donation 5 Other So 21. Significant of Funeral Services	pecify:	Bayvie Bayvie		er place) ematory ame and Address		2/2006	_		, Maryland
Balti Departi Import Import Import	23a Part I. Enter the disease, or	complications that cause	d the death Don	400	1 Ritchi	ie High	wav Ba	11timo	re. Ma	ice, P.A. ryland 21225 Approximate Interval
/Medical Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		e intoxica sequence of):	tion						Between Onset and Death
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or as a conductor) Due to (or as a conductor)								
e execution and train and train and train train.		XX AMENDED it	em#5,perIr	nf,G856	,6/7/06 T	Γ// iten	m#23a,27,			. 1
2 8 g E ∞		1 Live birth 4 Pregnant a	A Aller and a Contract of the sealer	2 Feta	al death 3 [er (Specify)	Ectopic pre	gnancy		Date of delive	very Day Year
ires that the case signed by the detached the detached the Dry Dry		ions contributing to dea	ith but not resultir	ng in the ur	iderlying cause gi	iven in Part I.				to the cause of death?
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer To the Funeral Director. After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.						-	- _ p	Vas an utopsy erformed? es 2 No	prior t death	
Vital E	25. Was case referred to medical examiner?	Hospital:	ient 2 🗸 ER/0	Dutpatient		of Death (Che Other 4 Nu	rsing Home 5	Residen	ice 6 Ot	her:
ion of trending Pheath tor: After true funeral	27 Manner of Death	28a. Date of In (Month, Day fing Fnd 5/28)		Time of In		y at Work? les 2 X No	28d Descr unk	be how injur	y occurred	
ig of a fine of the	3 Suicide 6 X Coul 4 Homicide deter 29a. Certifier 1 Certifying Pl	d not be 28e. Place of (Specify) 1	injury - At home, f ink				unk	n, State)		Rural Route Number, City
To the Ho within 24 P To the Fur completely	one) 2 Medical Exa	nysician: To the best of r miner:On the basis of ex and manner stated	amination and/or			death occurre		ate and plac	e, and due to	
Day.	30 Name and address of person	Lan	death (Item 23a)		O.C.N				29, 2006	
1000	David Fowler M.D.	Chief Medical Exar	niner 111 F	Penn Str		e, MD 212	01			
Stat Registra		2006 Block		Append						

			For State	State of Maryland	•	ent of Health a ate of Death	nd Mental I	, 0	0000	17011
	Physici	an	1. Decedent's Name (First, Middle, Last,	*/	ocrano.	Stanza i	2. Date of Month	D	ay Year	3. Time of Death
	/Medic Examir	al	4a. Fecility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of	Death	-	c. County of Death	16:17
	Funeral Director		THE JOHNS HE 5. Social Security Number 6. Sec 187-30-2226	pkins Hospi x 7. Age (In yrs. ias		der 1 Year I Under 2 hs Days Hours	Min. (Month	, Day, Yea	r) Cour	place (State or Foreign http://
	D		Usual Residence of Decedent 10a. State 10b. County		Town or Location		Jun- II	6,1937		Od. Inside City Limits
	4 within 72 hours after death with the Maryland jiene. r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at	ctor	PA YORK	V	ek.					1 ≝Yes 2 □ No
	with the	Director	10e. Street and Number		10f.	Zip Code			Citizen of What Cour	
	ems 23	Funeral I	936 E. Przinc	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was De	ocedent of Hispanic Orig specify Cuban, Mexican,	in? (Specify Yes o		14. Race - Americ Black, White,	an Indian,
036	urs after al', or its ramm	þ	1 Never Married 2 Narried 3 Widowed 4 Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		s 22 No Specify:	Table Hour, Go.	,	Specify: WIHI	
21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's L	Isual Occupation work done during most Tuse retired)	of working	16b.	Kind of Business/Inc	dustry
212		omo	Elementary/Secondary (0-12)	College (1-4or 5+)	. 1	maker		RE	DSONAL R.	ESIDENCE
and	ould be filed Mental Hygid arked other atic event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother	's Name (First, Mic		on Sumame)	
Maryland	d 2 should th and Men 7 is marke traumatic	2	ELMER KE LBAW 19a. Informant's Name/Relationship (Ty		19b. Mailing Addr	ess (Street and Number	OF RURAL ROUTE NO		or Town, State, Zip	Code)
_	1 and Heali em 2 ther		Dennis E. STONESTE 20a. Method of Disposition		936 E	Princess ST.	, Vork,	PA- 17	1403 Location - City or To	nun State
Baltimore,	9°= 5		1 ⊠ Burial 2 □ Cremation 3 🖎 4 □ Donation 5 □ Other (Specify)	Removal from State	netery, crematory	or other place)	May 30, 200			
Balti	permit. Pag Depertment Importent: any injury o		21. Signature of Funeral Strice Licens		2. Name	and Address of Facility			anover Pr	FRAT Home
			23a. Part1. Errer the disease, or complishock or heart failure. List only or	ications that caused the death.		MARKET node of dying, such as c		ry arrest,	PENNA	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Mitral	Re	gurgi-	tatio	n		Onset and Death
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or a) (Sche	mic (Card	iomy	yo pathy	2 years
P.O. Box 6	at the death certificate be execut by the attending physicien and tached for use as the burial-trar	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic	pregnancy (specify)			23d. Date of delive Month	ory Day Year
	signed d be de	þ	Part II. Other significant conditions cor	ntributing to death but not resulti	ing in the underlying	g cause given in Part I.			use contribute to th	
Vital Records,	The ete h page	Completed					a	Vas an utopsy erformed? es 2000	prior to con death?	osy findings available inpletion of cause of
f Vit	Physicien: 1 this certificel ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes	lospital: 1	R/Outpatient 3□	Othor	of Death Check or sing Home 5 F	11110 000	6 ☐Other (Specify	•)
	ing After une	Certification;	27. Manner of Leath 1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury M	28c. Injury at Work?	28d. Descri		ury occurred	
DIV	or A after Direct in by	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fac	tory, office		n (Street a Town, Stat	nd Number or Rural e)	Route Number,
	Hospitel	Medicai	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurr n and/or investigat	ed at the time, date and ion, in my opinion, death	place, and due to occurred at the tir	the cause(s ne, date an	s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2.	Me	29b. Signature and title of certifier			29c. License number		29d. Da	ate signed (Month, L	Day, Year)
,	n		30. Name and address of person who co	M.D.	(2a) /T. ac. Briet)	RES-OOC	· · · · · · · · · · · · · · · · · · ·	Ma	y 24,	2006
	100		Raquel Charles	600 N	ORTH	Wolfe !	Street	Bal	timere,	2006 4D 21287
	Sta Registr	te ar	31. Date filed (Month Pay Year) MAY 3 1 200	6 Registrar's Signatur	South					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:25 P M Anna Thompson May 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1100 Bolton Street # 705 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 □ M 2 🖾 F Yrs. Maryland Director 77 Nov 15, 1928 220-24-1148 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other then "netural", or Items 23a or 28a-f show vent, the Medical Examinar must be notified at 1X Yes 2 □ No Director Baltimore 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 1100 Bolton Street # 705 21201 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Infortant: If tem 27 is marked other then "natural; or fler important: If tem 27 is marked other then "natural; or let easy injury or other traumatic event, the Medical Examination one. 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Proctor Josephine Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney Lewis/niece 2819 Cunningham Dr. Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ADonation 5 ☐ Other (Specify) 21. Signature of Euneral Service S. W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director Ronald 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Emphesenz **Physician** /Medical Due to (or as a consequence of): Examiner 10 TV.T Dua to (or as a ronsequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 d Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ို this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural To the ruce after death.

Within 24 hours after death.

To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Rm 206

MAY 3 1 2006

31. Date filed (Month, Day, Year)

Migh- Over Kround Im p

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Entan street

Coertes

N.

32/Registrar's Signature

Marso D

29c. License number

031865

Bretimore

29d. Date signed (Month, Dey, Year)

19/66

State of Maryland / Department of Health and Mental Hygiene Amend Item #20b Per Fh G855 5/31/06 Pertificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Day Yaar GERTRUDE TUCKER 12:15851 MA-22 2006 /Medical 4a Facility Nama (If not institution, give streat and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner RANDALSTOUX Yaar If Undar 24 Hrs. 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 8. Data of Birth (Month, Dav. Year) Months Days Hours 1 M 2 N F 230-14-5721 Director Usuel Residenca of Dacedant Peges 1 end 2 should be filed within 72 hours efter death with the Merylend near of Health end Mentel hygiene. Intent of Health and Mentel hygiene. unt: If then 27 Is marked other than "netural", or hems 23a or 28e-f show ury or other traumatic event, the Medical Examinar must be notified at ury or other traumatic event, the Medical Examinar must be notified at 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Completed by Funeral Director MORE 1 ☐ Yas 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? OUR 1,5.A Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, White, etc. Was Decadent of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: 3 ₩idowad 4 Divorced 15. Dacedent's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retirad) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) JOWIL DEBBIE 19b. Mailing Addrass (Straet and Numbar or Rural Routa Numbar, City or Town, State, Zip Code) RYLE 20b. Place of Disposition (Nama of camatery, gramatory or other WSON 20a. Method of Disposition 20c. Location - City or Town, Depertment of H
Important: If Reany Injury or ott
once. 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signatura of Funeral Service Licensaa 22. Nama and Addrass of Facility 23a. Part 1. Enter the disease, of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death Physician /Medical Immediata Cause (Final disaasa or condition resulting in daath) 4 BARS OEMENTIA Examiner Dua to (or es a consaquence of): Examiner The lew requires that the deeth certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): attending | signed by the at d be deteched for Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ Completed certificate hes been s irector, pege 2 should 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformad? complation of cause of death? 1 Tas 2 🕅 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was casa rafarrad to madical axaminar? Be 26. Place of Daath (Check only ona) Other: 4 M Nursing Homa 5 Residenca 6 Othar (Specify) Hospital: Medical Certification: To 1 ☐ Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 🕅 Natural 5 Panding invastigation Injury 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Numbar, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner statad. 29a. Cartifiar 29d. Date signad (Month, Day, Year) 29b. Signature and title of certifiar 29c. Licansa number K.S.RAO.M.O. D43462 MAY 22, 2006 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 010 COURT NO WO 51133 #108 RANDALLSTOWN 31. Deta filad (Month, Day, Yaar) 32. Registrar's Signatura

DHMH 16 Rev 6/95

Registrar

MAY 3 1 2006

				State of Maryland / Depa				
				_ FOI	rtificate of Death		g. No.2006	17047
		Physici	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
		/Medic	al	Juanita G. Tearle	4b. City, Town, or Location of Death	May 29,	2006 4c. County of Deat	8:25 P M
		Examin	er	4a. Facility Name (If not institution, give street and number) 144 Hickory Avenue	Bel Air		Harford	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	TOTAL CONTRACTOR OF THE PARTY O	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
		Director		214-14-5458 S6 Yrs. Usual Residence of Decedent		Aug. 26,	1919 Mai	ryland
		yland how		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
		death with the Maryland ms 23a or 28a-f show	Director	Maryland Harford Bel Air				1 ☑ Yes 2 ☐ No
		with the		10e. Street and Number	10f. Zip Code		g. Citizen of What Co	untry?
		death ms 23	Funeral	144 Hickory Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21014 Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto		14. Race - Ame Black, White	
	92	or Ite	y Fui	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No	1 Yes 2 No Specify:	rican, etc.,	Specify:	
. 1	8	hours tural',	ed by	3 ∰Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Education 16a. Decedent's Education 16a.	dent's Usual Occupation	1	6b. Kind of Business/	nite Industry
7	215	hin 72 an "na Medic	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	ing		.,
13	21	ygiene ygiene ner the		12 Clerk	10 Mahada Nom	e (First, Middle, M	communicat	Lon
10	and	d be fill antal H ed ott	Be c	17. Father's Name (First, Middle, Last) John (nmn) Griffin	Mattie		Kellso	
	Maryland 21215-0036	shoul ind Me s mark umati	To		ng Address (Street and Number or Run			(ip Code)
14	Ž,	and 2 ealth a n 27 is			H Running Creek W			
Tuanita	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event. The Medical Examilian must be notified at 20ce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		Oc. Location - City or	
Ta	ij	nit. Pa artmer ortent injury			Service Corp. 5-31 2. Name and Address of Facility CComas Funeral Hon	and the second s	owson, Mar	yıand
	B	Depar Impo eny ir once.		11. SULVER 11/1000013	317 Cokesbury Road	l, Abingd	on, Maryla	and 21009
				23a. ani . Enter the disease, or complic nons that caused the death. Do not ent shock, or heart failure. List only on cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Qnset and Death
		Physician /Medical		resulting in death)	wentee whis			1 day
		Examiner		August (or as a consequence of):	c culovascul	V seen	ce	10 70000
		D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				1000
		be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence ot):				
	760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	calE	d				
	.89	that the death certificate ed by the attending physi detached for use as the I		IF FEMALE:				
	Box 68	ath ce ttendii	lan/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
	P.O.	the de y the a iched f	Physician/Medi	1 Yes 2 No 9 Unknown	Other (specify)			
		s that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to	
	ord	iw requires that s been signed b should be deta	Completed by	Great Carren		1 🗆 Yes	s 2 No 3 Pr	obably 4 Unknown
	3ec	e law has b	mple	Pancreutits.		24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
	la	in: Th ificate or, pag	e Co	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2		2 No
	ίV	nysicie nis cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		nce 6 Other (Spec	cify)
	0 0	ing Pt		27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \) No	28d. Describe how	w injury occurred	
	Division of Vital Records,	Attend death ctor: ,	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, At home, farm, str			eet and Number or Ru	ıral Route Number,
	Ö	s after s after el Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated				
		To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of confider	29c. License number	177	d. Date signed (Monti	* * * * * * * * * * * * * * * * * * * *
		- > - 0		TILL A DO FACE	H34022	111	Ay 30	2006
	-	7 - 1		30. Name and address of person who completed cause of death (Item 23a) (Type,	(10 / 11)	1. 51	Ay 30	-
			ate	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	rese (eren pp)	ty lay	ewil M	V
		Regist		MAY 3 1 2006 Degree 15 19				

		1 - For State Registrar	State of N	larylan		rtment of h		d Mental Hy	giene Reg. No.	06	17048
1.1		1. Decedent's Name (First, Middle, La	st)					2. Date of D		V	3. Time of Death
Physici		John Ship	lev	Tait				Month	26	2006	12:20A M
/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of D			nty of Death	
.4.		3234 Ludham Dr.				Silve	r Sprin	.g	Mo	ntgom	ery
Funeral		5. Social Security Number 6. S			last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bi			place (State or Foreign
Director		578-34-9904	X]M 2□F	76	Yrs.	Months Days	Hours	June 2	3,1929	New	
<u> </u>		Usual Residence of Decedent									
rylar how	_	10a. State 10b. County		10c. City	y, Town or Lo		0			1	10d. Inside City Limits
9 Ma	cto	Maryland Montgo	nery			Silver	Spring				1 ☐ Yes 2XXVo
should be filed within 72 hours after death with the Maryland and Mantle Hygene. In arked other than "natural" or items 23s or 28s-1 show unastic event, the Madical Exerting from the incilling at	Funeral Director	10e. Street and Number 3234 Ludham Dr.				10f. Zip Code	20906		10g. Citizen o		,
23a	ra l	JZJ4 Ludham DI•								d Sta	
tam tam	rue	11. Marital Status	12. Was Deceder Amed Forces	5?	S. 13.	Vas Decedent of I I Yes, specify Cub	dispanic Origin an, Mexican, P	? (Specify Yes or Note:	o- 14. R	ace - Americ lack, White,	
at a la	by Fe	1 ☐ Never Married Married Widowed 4 ☐ Divorced	1 Ayes 2 If Yes, Give			Yes 2 No	Specify:		Spec	city: W	hite
ural'	Q D		Year or Dates	:	tCo David	lantin Haval Oncor			10h Kind of	Dunings (In	du
72 r	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of d)	working	160. Kind of	Business/Inc	bustry
withii then	E	Elementary/Secondary (0-12)	College (1-4o	r 5+)		ectronic			E1	lectro	nics
Hygint, ther		17. Father's Name (First, Middle, Last)	_					Name (First, Middle	·		
of be	Be c		ifford	Tait	۲		Loya		abeth		pley
d Me	မှ	19a. Informant's Name/Relationship (141		n Address (Street		r Rural Route Numb			
d 2 s th an 7 le		Jewell K. Tait						lver Spri		2090	
Heali Heali ther		20a. Method of Disposition		20b. P		sition (Name of natory or other pla		Date	20c. Location	n - City or To	own, State
or or or		1 ☐ Burial 2 ☐XCremation 3 ☐						127/06		ville	
rtmer rtant		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Lice)				ake Crema					, FID
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene. Department of Hygiene. Department of Hygiene.		1 4 1 Y	//	M003				remation			
		23a. Part1. Enter the disease, or com	MMELLA					ilver Spr		20910	Approximate
		shock, or heart failure. List only	one cause on each	line.	i. Do not ent	or the mode of dyn	ig, such as can	diac or respiratory a	arrest,		Interval Between Onset and Death
Physician	173	Immediate Cause (Final disease or condition resulting in death)	Lung C								ı year
/Medical Examiner			Due to (or a	is a consequ	uence of):						
	4	Sequentially list conditions,	b. Due to for a	as a consequ	uence of						
SE A SE	Examiner	Sequentially list conditions, the sequentially list conditions, cause. Enter Undertying Cause (Disease or injury									
and and	xar	that initiated events resulting in death) Last	c Due to (or a	is a consequ	uence of):					-+	
ures that the death certificate be executed signed by the attending physician and die detached for use as the burial-transit	caiE										
phys phys s the			_ d.								
ding se as	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ncv				224 [Date of delive	201
atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	Ectopic pregnanc Other (specify) _	у			Month	Day Year
the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		Juli 7	, other (apo ony) _					
that if		Part II. Other significant conditions of	ontributing to death	but not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ontribute to th	he cause of death?
sign d be	d by							1 😿	Yes 2 No	3 Prob	pably 4 []Unknown
ding Physician: The law requir h. After this certificate has been si funeral director, page 2 should	Completed							24- 146-	0.0		and the state of t
e law has l	mp							— 24a, Was			mpletion of cause of
th: Th	S							1 ☐ Yes		1 🗆 Yes	2 1 No
ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			0.00		Death Check only	one)		
Phya this c	2	1 ☐ Yes 2 ▼No	1 🗀 Inpa		ER/Outpatien	1 3L DOA		ng Home 5 Res			y)
ding f	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, L	Day Year)	28b. Time of Injury	Wo			how injury occ	urrea	
Seath Seath tor: ,	cat	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2 □ No		(Cara-a - a d A)		
or At fter o	Certification:	4 Homicide determined	286. Place of	etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office			(Street and Nut own, State)	mber or Hura	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the		202 Cartifier (The attain - 2)	veleior: To the I	nt of much	wlade- 1		mo dete	lace, and due to the	00000-(-) :		loted.
Hos 24 ho Fun Itely	edicai	29a. Certifier 1 V Certifying Pt (Check only 2 Medical Examone)	niner: On the basis and manner	of examina	tion and/or in	estigation, in my	me, date and p opinion, death o	occurred at the time	date and place	e, and due to	the cause(s)
ithin ithe	Med	29b. Signature and title of certifier	and manner			29c. Licens	se number		29d. Date sign	ned (Month.	Day, Year)
6 3 5 4		X100	116						5/26		
18	V	7000	~~~		00-1-7	D459	080		2/00	100	
15		30. Name and addless of person who	completed cause of	death (Item	1 23a) (Type,	MD 71	850				
Sta		31. Date filed (Month, Day, Year)	Piccord D	strar's Signa	ture	1-1-10					
Sta Regista		MAY 3 1 2	2006	bace 4	4 A	and I					

			For State Bagistrar	State of	of Marylan					and M	-		-2.0	06	1704
					-						2. Date of De	ath			3. Time of Death
			KATHRYN H. TOWS	ON							Month MAY	26 ^{Da}	2	ďobarová od od od od od od od od od od od od od	02:35p M
			4a. Facility Name (If not institution, give s	street and nu	ımber)		4b. City,	Town, or I	Location c	of Death		4c	. County	of Death	
			MARINER HEALTH	& REF	IAB. CE	ENTER						H	IARF	ORD	
Deceder of Name (First, Models, Last) Certificate of Death Rep. No. U. Certificate of Death U. Certif															
bu					10c Cit	v Town or Lo	cation							1	0d. Inside City Limits
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death	ma 2	era		12. Was Dec	edent Ever in U	.S. 13.	Was Deced	dent of His	panic Ori	gin? (Spe	cify Yes or No)-			
afte	or its	Ē	1 Never Married 2 Married	1 ☐ Yes	2 No					, Pueno r	nican, etc.)				
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2 iii	Hygi Tr					2200			18. Mothe	r's Name	(First, Middle				
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	Deper impor		21. Signature of Funeral Service License	asse		I I	IENRY	W.	JEN	KINS	S & SC ONKTON	NS ,MD	CO.	1111	•
			23a. Part1. Enter the disease, or compliant shock, or heart failure. List only on	cations that e cause on	caused the deatleach line.	h. Do not ent	er the mod	e of dying,	, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between
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te be	ysicle na bur	cal													
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ath ce	ittend or us	an/	23b. Was decedent pregnant 23	1 Live	birth 2 Feta	Ideath 3									*
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thet	ed by deta		Part II. Other significant conditions con	tributing to c	leath but not resi	ulting in the u	nderlying c	ause giver	n in Part I.		23e. Did t	obacco u	ise contri	bute to th	e cause of death?
uires	n sign										10	Yes 2	No :	3 🗌 Probi	ably 4 Unknown
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hysic	his ce	0		ospital: 1 □	Inpatient 2	ER/Outpatien		A	4/23 Nui	rsing Hom	e 5□Resi	dence	6 □Othe	r (Specify)
ing P	After t	on:	1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)						8d. Describe I	now injur	y occurre	d	
ttend	death stor:	Icat	3 Suicide 6 Could not be	28a Place	e of Injury - At ho	me farm etc			es 2		8f Location (Street an	d Numbe	r or Rurai	Route Number,
	effer Direct d in by	ertif	4 Homicide determined	build	ing, etc. (Specif)	y)	eet, lactory	, once			City or To	vn, State)	r or riura,	HOSTA MULTIDAL,
Hospital or	within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the b	e best of my kno pasis of examinationer stated.	wledge, death tion and/or inv	occurred vestigation,	at the time in my opi	, date and nion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) date and	and man place, a	ner as stand due to	ated. the cause(s)
o the	vithin To the	Me	29b. Signature and title of certifier				290	. License	number			29d. Dat	e signed	(Month, L	Dey, Year)
-	> - 0		* NNM	7			0	346	52		1	MA	Y 30	ZX	6
	13		30. Name and address of person who con SCOTT HASWELL M		se of death (Item		Print)			BELA	AIR,MI). 2		<i></i>	
	Sta Registra		31. Date filed (Month, Day, Year) MAY 3 1 2006	29. F	Registrar's Signa	ture					•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. --1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1230 PM 25 MAY 2006 /Medical City, Town, or Location of Death 4c. County of Death Fecility Name (If ot institution, give street and number) Examiner en nder 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Yrs. Director Usual Residence of Deceden should be filed within 72 hours effer death with the Maryland of Mental Hygiene. marked othar than "natural", or Itame 23a or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itame 23s or 28s-f show other traumatic event. The Medical Examinar must be inclined at 1 es 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates þ ₩idowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) permit. Peges 1 end 2 should be file.
Deperment of Health and Mental Hygis
Importent: if itam 27 la marked of any injury or other to 18. Mother's Name (First, Middle, Maiden Sumame) (First, Middle, Last nt's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Cremation ☐ Other (Specify) 3 Removal from State 1 Burial 4 Donation 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not ent-shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician DU 150 remore /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Aftar this certificate hes been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mort Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 □tinknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed2 201 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 2 **∑**∕No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 25 2006 youraghe. AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

MEMORIAL

HOSPITAL

UNION

Registrar's Signature

Market .

GALLAGHER MY

CATHERINE

31. Date filed (Manta Pay Year) 2006

				For State Registrar	State of Ma	arylan	-	artment of F	Health and I		_	C) 47	e and one and
		Physici	an	1. Decedent's Name (First, Middle, L				timoato or	Dodin	2. Date of De	ath Day	Year	3. Time of Death
		/Media	al	Christine Wel				4h Cib. Town		11191	27	2004	8:08am
	1	Examir	er	4a. Facility Name (If not institution, g	ive street and number)	+21		4b. City, Town, o	or Location of Death	n .	4c. County	of Death	
		Funeral			Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Oct 24			lace (State or Foreign
		Director		Usual Residence of Decedent	70 W 20XF	3	93 Yrs.			Oct 24	, 1912		'I'and
		ahow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	Od. Inside City Limits
		Ba-f	ecto	Maryland Baltim	ore			Catonsvil	.le				1 ☐ Yes 2 ☐XNo
		with t	ā	10e. Street and Number 6620 Kilmarnoch	Drivo			10f. Zip Code	228		10g. Citizen of V	Vhat Cour SA	ntry?
		deeth	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.		Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No		e - Americ	an Indian,
	36	ours after deeth with the Maryla rel', or Items 23a or 28a-f e.hov Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🔀 I If Yes, Give	No		1 ☐ Yes 2 💢 No		o nican, etc.)		k, White. : Whi	
	21215-0036	72 hours natural;	ted b	15. Decedent's	Year or Dates: Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu		
	215	swithin 72 ho liene. r than "natur the Medical	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	5+)			during most of word)				
	d 21	filed w Hygier other th	S	12 17. Father's Name (First, Middle, Las	st)		Admir	nistrativ	re Assista				County
	Maryland	a la b	To Be	Elija Milton Wel						nina Spi		,	
	lary	s 1 and 2 should f Health and Men ltem 27 is marks other traumatic	Γ.	19a. Informant's Name/Relationship					and Number or Ru	ral Route Numbe	er, City or Town,		
		1 and Health em 27 ther t	1	Franklin Walter,	Son	20b. P			ch Drive	Catonsv	ille, M		
	JOL			1 ☐ Burial 2 ☆ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				esition (Name of matory or other place	Inc. 05/3				Mary land
	Baltimore,	permit. Pege Department of Important: If any injury or once.		21. Signature of Ayneral Service Sic	energy win	- 110		and the second second second					
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				23a. Part1. Enter the disease, or co shock, or heart failure. List one Immediate Cause (Final	y one cause on each lif	ne.	1 .	11	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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	п	Examiner		Sequentially list conditions.	b. Sever			rgurg	itation			r	nonths
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	8760,	sate be executed hysicien and the burial-transit	dicai	•	d								
\	9 X		/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	ncv						
2	. Bo	death e atten id for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1☐Live birth 4☐Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d. Dat Mor	e of delive nth	ry Day Year
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time	of Vital Records,	se og e	d by	Part II. Other significant conditions	contributing to death bi	ut not resi	uiting in the ur	nderlying cause giv	en in Part I.		_	ibute to th 3 Proba	e cause of death?
lalter, Christ	eco	ie law requir hes been s je 2 should	Completed							24a. Was autop		Vere autor	osy findings available
3	<u> </u>		Con							perfor	mied? d	eath?	20-No
3	ĬĬ.	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	·		Oth	26. Place of Deal				
7		ng Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Injui (Month, Da)		28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing Ho y at		ow injury occurre)
2	siol	Attending r death. ector: After by the fune	catic	1 Natural 5 ☐ Pending 2 Accident investigati 3 ☐ Suicide 6 ☐ Could not	on he			M 1 🗆	Yes 2 □ No				
7	Division	or Attano efter death Director: I in by the	Certification:	4 Homicide determine		ury - At ho c. (Specify	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rurai	Route Number,
		To the Hospitel or Attending Physicien: within 24 hours delte dealt To the Funeral Director: After this certific completely filled in by the funeral director,	licai	(Check only 2 Medical Exa	Physician: To the best of the basis of and manner sta	examina	tion and/or inv	estigation, in my o	pinion, death occur	red at the time, o	date and place, a	nd due to	the cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier	4/1			29c. Licens	e number	· ·	29d. Date signed	(Month, L	Day, Year)
)	λ		Idana Ho	aren, M.D.			Do	05609	12 1	nay.	27,	2004
		8		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type.)	Print	re Ba	ltimo	r. ma	nyla	nd ZIZZG
		Sta Registr	te ar	29b. Signature and title of certifier CACHA M 30. Name and address of person who CACHA M 31. Date filed (Month, Day, Year) MAY 3 1	2006 32 Aegistra	ar's Signa	ture do	and a				-	

06-03463 Please Type or Print in Black Indelible Ink Nathaniel Wagstaff State of Maryland / Department of Health and Mental Hygiene Amend #20b Per FH G856C6/Fig. 4060f peath Registrar Reg. No Physician/ Medical Examiner 2. Date of Death Month nani May 22, 2006 0149 hrs 4a. Facility Name (if not institution, give street and number c. County of Death 1807 West Lafayette Avenue Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Director Months Davs Hours Min oreian 1 X M 2 Country) Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No items 23a or 28a-f shoust be notified at once Director 10e. Street and Numbe 10g Citizen of What Country Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Race - American Indian, Black Armed Forces? Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Yes Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 No specify: "natural" 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) 2 should be filed within 72 h n and Mental Hygiene. 27 is marked other than "n matic event. the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Father's Name (First, Middle, Last) rtant: If item 27 is marked Be (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cemetery, Baltimore, Burial 2 Cremation crematory or other place? 3 Removal from State nent Donation 5 Other Specify Green Mount Crematory gnature of Funeral Service License 22. Name and Address of Facility rt I. Enter that isease, or complimion lure. List only one cause on each line **Physician** the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval /Medical Between Onset and Dilated cardiomyopathy Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical X UNPENDED AMENDED item#23a,PII,27,perME,G856,6/1/06 TT Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ö 23e. Did tobacco use contribute to the cause of death? Completed by ۵ kidney failure; cocaine use Yes 2 No 3 Probably 4 🗸 Unknown Division of Vital Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ this Inpatient 2 ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending Yes 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be

Funeral Director: To the

Medical

Homicid 29a. Certifier 1

Ling Li, MD

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 22, 2006

			For State Registrar	State of Ma	ıryland		artment of h tificate of		-	gienę' 📗 Reg. No.	16 1/05	3
4		ý.	Decedent's Name (First, Middle, Last	st)					2. Date of Dea	ath	3. Time of De	ath
*.5	Physicia	_	James Woolery						May 30		5:40	РΜ
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	or Location of Dea		4c. County o	f Death	
1			Harbor Hospital				Baltimo	re		Baltim	ore City	
*	Funeral	- 1 - 5	5. Social Security Number 6. S		(In yrs. las	st birthday)	If Under 1 Year				Birthplace (State or Fo Country)	oreign
	Director		405 40 0352	M 2□F	75	Yrs.	Months Days	Hours Mill	Sept. 4	, 1930 K	lentucky	
	P.		Usual Residence of Decedent									
	show	_	10a. State 10b. County		10c. City,	Town or Lo	cation				10d. tnside City L 1 ☐ Yes 2 €	
	Ba-f.	ct	Maryland Anne Arı	ınde1	Pasac	lena						Ö 140
	or 2	Director	10e, Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?	
	be filed within 72 hours after death with the Maryland ital Hygiene id other than "natural", or liems 23a or 28a-f show event, the Medical Exeminal must be notified at		204 Catalfa Ave.	,			21122			United		
	tema pr.ma	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Pue	Specify Yes or No- ito Rican, etc.)		- American Indian, , White, etc.	
ည	or i	by Fi	1 □ Never Married 2 ☑ Married	1 GYes 2 □ N If Yes, Give	° Korea	an 1	☐ Yes 2X No	Specify:		Specify:	TT	
21215-0036	ural	g p	3 Widowed 4 Divorced	Year or Dates:	Wai	<u> </u>				40b 165-4-4 D	White	
Ÿ	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		(Give	ent's Usual Occup kind of work done OO NDT use retire	during most of wo	orking	16b. Kind of Bus	.ness/industry	
2	withir ane.	Ę.	Elementary/Secondary (0-12)	Cotlege (1-4or 5	+)			۵)		Stee1		
N	filed with Hygiene ther the		17. Father's Name (First, Middle, Last)			Sceen	worker	18. Mother's Na	me (First, Middle,)	
Maryland	should be filed within 72 hours after death with the Marylan nd Mental Hygiens marked other than "natural", or liems 23a or 28a-f show mailc event, the Medical Examinar must be notified at	Be	Louis Woolery					Martha	Carroll			
2	is 1 and 2 should life walth and Men liem 27 is marks other traumatic.	၉	19a. Informant's Name/Relationship	Tyne. Print)		19b. Mailin	a Address (Street		ural Route Numbe	r City or Town S	tate Zin Code)	
Za	nd 2 shoulth and 27 le m	Ì							adena, M		2.0, 2.5 0000)	
ď,	1 and Health em 27 ither ti		Betty M. Woolery 20a. Method of Disposition	/ Wife	20b. Pla	ce of Dispos	atalfa A		Date Date		ity or Town, State	
وَ	Pages nent of I int: If Its iry or o		1 ☐ Bulliat 2 ☐ Cremation 3 ☐		Cross	mesri 1	iatory or other pla .1e MD	Juli	ie 5 106	Cmorman	1110 Marril	د ـ
altımore,	rtme rtant njury		4 □ Do ation 5 □ Other (Specifical Service Licer		Vēte	ranc	Cemetery			Crownsv	ille, Maryl	ana
Ra	permit. Pages Depertment of h Important: If Ite any injury or of		The state of the s			K 1 42	rkley-Ru 1 Crain	iddick Fu Hwy., S.	neral Ho	me, P.A. Burnie,	MD 21061	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mode of dyil	ng, such as cardia	ic or respiratory ar	rest,	Interval Betwee	ın
	Physician		Immediate Cause (Final disease or condition	Phe	11 ma	n19					Onset and Dear	2
	/Medical		resulting in death)	Dye to (or as a	• • •							
	Examiner		Constitution the line and distance	Heme	Ent.	K			At .		Syear	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	nce of):	1 L.		0			
	cuted	Examin	Cause (Disease or injury that initiated events	· 1745	my	910p	163116		Indra	ne	54841	
o O	en ar	EX	resulting in death) Last	Due to (br as a	conseque	nce of):		/	/		/	
8/60,	icate be executed physicien and s the burial-transit	dicai	(d								
9	ng pt		IF FEMALE:									
Š	death certifii e attending f id for use as	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnance	у		23d. Date Monti		
<u>n</u>	0 0 0	sici	in the past 12 months? 1 Yes 2 10	4☐Pregnant at 9☐ Unknown			Other (specify)			Monti	h Day Year	
r Ö	at the	چ	9 Unknown				- 2					
	requires that the de peen signed by the a hould be detached f	ρ	Part II. Other significant conditions of	ontnbuting to death bu	it not result	ing in the un	derlying cause giv	ven in Part I.			ute to the cause of death	
D	w requir been si should	ed							1 U Y	es 2 2 10 3	Probably 4 Unkr	lown
Hecords,		Completed							24a. Was autop		ere autopsy findings avai or to completion of cause	
	0 - 6	E							perfor	med? dea	ath? Yes 2	
Vital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical					26. Place of De	ath_(Check only or			
	%	To E	examiner? 1 Tes 2 Tho	Hospital: 1 Inpatier	nt 2006	NOutpatient	3□ DOA Ott	ner: 4 Nursing I	Home 5 Resid	ence 6 Other	(Specify)	
וס ר			27. Manne of Death 1 ☑Naturat 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury	28c. Injui Wo	ry at	28d. Describe h	ow intury occurred	1	
<u></u>	Attanding or death. ector: After by the fune	atlo	2 ☐ Accident investigation	1		,,,,,,		Yes 2 □No				
DIVISION	er de recto by th	E 1	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At hom	e, farm, stre	el, factory, office		28f. Location (S City or Tow	treet and Number n. State)	or Rural Route Number,	
5	s afte	Certification:			. (-27)							
	To the Hospitel or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exan	ysician: To the best onliner: On the basis of								
	the hin 2 in 2 the f	led	one)	and manner sta								
	To To Con	~	29b. Signature and title of certifier	K1.+.		1	29c. Licens	e number	() '	esd. Date signed (Month, Day, Year)	
	,		· Well /	NVW VS	MY	/	ν	1007	7 .	15/10	6	
	6		30. Name and address of person who	1 ./	ath (Item 2	3a) (Type, F	/ 1	10 11	00.0	116 8	Chip 1.1	
	J		C111011 1701	batymo	14	1/ /	7991Jan	PATIC	Willy	VICE D	VI My	1106
1000	Sta Registr	_	31. Date filed (Month, Day, Year) MAY: 3 1 200	6 Registra	rs Signatui	A COSA	K)		,		' /	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Ina M. Wilder MAy 10:60 AM 28 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ivy Hall Nursing Center Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July21,1914 **Funeral** Birthplace (State or Foreign Country) 215-22-3076 Months Days Hours Min. 1 □ M 2 € F 91 Director Tenn Usual Residence of Decedent 10a State 10b. County or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits the Medical Exerciner must be notified at MD Baltimore Director Middle River 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Helicopter Drive 21220 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours atter ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural; or Ite ury or other traumatic avent, the Medical Exert in Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SAmuel Greene Julia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herschel Wilder / son 22 Glider Drive Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 5/31/06 Department of Important: If any Injury or Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balt Connelly Funeral Home of Essex Balto. MD ssex 21221 23a. Part1. Enter the disease, or combications that caused the death, shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listed executivity) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last P.O. Box 68760. attending physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the aid 4☐Pregnant at time of death Month Dav Year 5 Other (specify) 9 Unknown 9 DUnknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has autopsy performed certificate 1 Yes 20 nours efter death.

neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ M Other Certification: To ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stype, Print) Place Dundalle MO State Registrar 1 2006

06-03640 Odell Wagner

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		ficate of D	eath	R	eg. No 200	6 1705
Physician/ Medical Examiner					2. Date of Dea Month May 28 , 2		3 Time of Death 2202 hrs
1	4a. Facility Name (if not institution, gr University of Maryland Sh	ock Trauma	E	City, Town, or Location of Baltimore		4c. County of Death	
Funeral Director		7. Age (In yrs. last		f Under 1 Year If Under Months Days Hours	Min	th(MM/DD/YYYY) 9. Birt Foreig Co.	hplace (State or n untry) Mary land
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
, or 28a-f show any fred at once, Director	Maryland N	A Balti					1 X Yes 2 No
rith the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 2538 W. Pratt Street			21223		0g. Citizen of What Cour USA	try?
or items must be		1 Yes 2 X No	If Yes,	ecedent of Hispanic Orig specify Cuban, Mexican, s 2 No specify	Puerto Rican, etc.)	White, etc	k
5-0036 led within 72 hour tygiene other than "natu the Medical Exan Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)		Jsual Occupation (Give Foot of working life, DO NOT		16b. Kind of Business/lr	ndustry
0036 within iene ier than Medic	12	NA NA	Graphi			Sweet Heart	Сир
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ce event, the Medica	Lucher wagner			Ellora			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Merital Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	19a Informant's Name/Relationship (1 Ellora Hicks mother	r	1319 W.	Pratt Street	ber or Rural Route Num Baltimore, Ma	nber, City or Town, State, aryland 21223	Zip Code)
ges l an tof Hea	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State crer	ce of Disposition matory or other i ion Cemete		Date June 2, 2006	20c. Location - City or	
Baltim permit. Pa Departmen Important injury or	Donation 5 Other Specify Signature of Foneral Service Licer	nsee		and Address of Facility		Lansdowne, Ma	arytand
- 11	230 Port Eats the		638 N	I. Gilmor Stree	et Baltimore.	Maryland 2121	
Physician // // // // // // // // // // // // //	23a. Part 1. Enter the inseas, or comp failure. List only one cause on ea	plications that caused the death. Do ach line. Multiple Gunshot Wounds		node of dying, such as ca	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	102 102 1 1 10 1	Due to (or as a consequence of):	•				
ner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying Cause.	Due to (or as a consequence of)					
red Insit	(Disease or injury that initiated C.	Due to (or as a consequence of).					7
50, te be executed ysician and burial - transit	d. UNPENDED	AMENDED	***				
8760, ificate be execute by physician and us the burial - tra	IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, outcome of pregnan				23d. Date of delivery	
Box 687 c death certiff the attending ed for use as t hysician.	past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal d	eath 3 Ectopic	pregnancy	Month Da	ay Year
P.O. Bc that the des ned by the a detached for by Physe	Part II. Other significant conditions	THE RESIDENCE OF THE PROPERTY OF THE PARTY O	Iting in the unde	rlying cause given in Par		bacco use contribute to the	
Is, P.(quires that en signed ald be det		-				2 No 3 Proba	
Records, The law require. ficate has been sig. page 2 should be					24a Was a autops perform	prior to co med? death?	ppsy findings available mpletion of cause of
tal Recidian: The lician: The lician: The lician: The lician rector, page rector, page Be Com	25. Was case referred to medical			26.Place of Death (1 Yes 2 Check only one)	No 1 Yes	2 No
f Vita Physici or this c ral direc	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 VER				Residence 6 Other	
Division of Vital Records, P.O. spiral or Attending Physician: The law requires that the rours after death meral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deated Certification: To Be Completed by F	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	May 28, 2006 21	Bb. Time of Injury	28c. Injury at Work?	Subject shot	ow injury occurred	
Divis Divis ours after dours after filled in by	3 Suicide 6 Could not determined	be 28e Place of Injury - At home	e, farm, street, fa	ctory, office building, etc	or Town, St	treet and Number or Rura ate) k Avenue, Baltimor	
the Ho hin 24 h the Fu npletely	29a. Certifier 1 Certifying Physici	ian: To the best of my knowledge, or: On the basis of examination and/o			ce, and due to the cause	e(s) and manner as starte	d
To with Con	29b. Signature and title of certifier	and manner stated		29c. License number		29d. Date signed (Mont	h, Day, Year)
	CaLILLO	completed source of death (the 200	0)	O.C.M.E.		May 29, 2006	
			*	treet, Baltimore, M	D 21201		
State Registrar	31. Date filed (Manth, Day, Xear) MAY 3 1 20	32. Registrar's Signature	hast	·			
Driver to Rev 1/2001		1,7-1-4-1-5-1-5-1-5-1-5-1-5-1-5-1-5-1-5-1-5	RIGINAL				

			For State Registrar		State	of Maryl	and / De		nt of H	lealth and Death	Mental Hy		2006	1705
-	Physicia	an	Decedent's Name	e (First, Middle, L		=1-1					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al -	4. F. W. Mana //	f and implication of		Elaine	IVI. VVO		T	- (t) 4 D t	Ma		2000	12 15 K-M
	Examin	er	4a. Facility Name (III				ul Cent		y, Town, o	r Location of Deat	n n.0		nty of Death	inda)
	Funeral		5. Social Security N		Sex		yrs. last birth	day) If Und	ter 1 Year	If Under 24 Hrs	8. Date of Bir (Month, Da			place (State or Foreign
	Director		215-32-	1550	1□M 2 X F		72 Yr	s. Month	s Days	Hours Min.		iy, rear) 5, 1934		Maryland
	pui	-	Usual Residence of 10a. State	Decedent 10b. County		10c	City, Town	or Location						I0d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow than "matical Examiner must be notilified at	jo	Maryland	·	e Arundel	1.55	o.,, , , , , , , , , , , , , , , , , , ,	or Education	Р	asadena				1 ☐ Yes 2 ☐ No
	h the	Completed by Funeral Director	10e. Street and Nur	mber				10f. 2	Zip Code			10g. Citizen	of What Cour	ntry?
	23a c	alD	8102 Hogi	neck Road						21122			U.S.,	A
	er dez	une	11. Marital Status		Armed I		n U.S.	13. Was Dec If Yes, sp	cedent of H becify Cuba	lispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.))- 14. I	Race - Americ Black, White,	
336	urs aft	by F	1 ☐ Never Marri 3 ☐ X Widowed	ied 2 Married 4 Divorced	If Yes, C Year or	2 □ X No Bive Dates:		1 🗆 Yes	2 1 000	Specify:		Spe	cify:	Black
ก <i>e</i> 21215-0036	2 hou	ted	/Cno.	15. Decedent's	Education	4)	16a. D	ecedent's Us	sual Occup	ation	rking	16b. Kind o	f Business/In	dustry
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Elaine ryland 213	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow or other treumatic event, the Madical Examiner must be natified at	To Be	17. Father's Name		es Colbert					to. Mother's Na	ne (First, Middle Cathe	erine Cha		
~@	12 sho h and 7 is mu treuma	9	19a. Informant's Na	ame/Relationship			19b. A	-		and Number or Rock		er, City or To	wn, State, Zip	Code)
Worrell altimore, M	1 and Health em 27		20a. Method of Disc		ugniei	20	b. Place of Control				Date	20c. Locatio	on - City or To	own, State
Jon Lor	Pages nent of int: If It			☐ Cremation 3 5 ☐ Other (Spec		n State				^(e) Mausoleum	06/03/06		rooklyn P	
Worre Baltimore,	in production		21. Signature of Fu			P-1	Occur i	22. Name	and Addre	ss of Facility	8 1			
ñ	Department of the sany is any		JU	uld	YYI.	85/		-	Estep E 1300 E	Brothers Fun- utaw Place F	eral Service Baltimore, M	P. A. d 21217		
	Physician /Medical		23a. Part1. Enter the shock, or hea the shock or head the shock of the	(Final	a. ATUE	t caused the di each line.	CEE	enter the m	ode of dyir	ng, such as cardia	or respiratory a	rrest,	ASBASE	Approximate Interval Between Onset and Death
	Examiner		Sequentially list co	nditions.	b. M.€	EJA3	otic	Ex	4 (F	RHALO	PATH	Y		
	sit sit	Examiner	Sequentially list confrant, leading to imcause. Enter Unde Cause (Disease or that initiated events)	nmediate ortying	Due to	o (or as a con:	sequence of)	100 4=	- (l	- ·		(
k	and and Il-tran	хап	that initiated events resulting in death) I	Last	c. Due to	o (or as a con	sequence of)	· VI CAE	- LU	ins				
(092	ate be executed sysicien and he burial-transit	calE				22	WRE	D	SOF	DER				
89	ificate g phy: as the	_			0.									
P.O. Box	Physicien: The law requires that the death certificat this certificete has been signed by the attending phyral director, page 2 should be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live	outcome of pre birth 2 T gnant at time on tnown	etal death	3 Ectopic 5 Other (Date of delive Month	ery Day Year
JS, P	ries that signed b	þ	Part II. Other signif	ficant conditions	contributing to	death but not	resulting in the	he underlying	g cause giv	en in Part I.		obacco use c		ne cause of death?
COL	w requires to been signed should be	letec									24a. Was			psy findings available
Division of Vital Records,	The lav	Completed									autor		prior to cor death? 1 \(\sum \text{Yes} \)	impletion of cause of
ita	icien: Th certificete rector, pag	BeC	25. Was case refer	red to medical						26. Place of Dea	1 ☐ Yes ath (Check only o		1 105	2 140
>	Physicien: this certific ral director,	10	examiner? 1 Tes 2	No			2 ☐ ER/Outp	atient 3 [4 🗆 INUISING F	lome 5 ☐ Resi	dence 6 🗆	Other (Specify	()
2	ding Phy h. After thi funeral o		 Manner of Death Matural 	5 Pending		e of Injury onth, Day Year	r) 28b. Tin Inji	ıry	28c. Injur Wor		28d. Describe	now injury oc	curred	
isio	Attending r death. ector: After by the funer	cat	2 ☐ Accident 3 ☐ Suicide	investigati 6 Could not	be age Pla	ce of Injury - A	At home farm	M street facto		Yes 2 □ No	28f Location /	Street and Nu	mher or Rura	l Route Number.
Div	Itel or Attend rs after death al Director: ,	Certification:	4 Homicide	determine	buil	ding, etc. (Sp	ecify)				City or To	vn, State)		
	To the Hospitel or a within 24 hours atter within 24 hours atter To the Funeral Direction completely filled in b	edical	29a. Certifier (Check only one)	1 ☐ Certifying F 2 ☐ Medical Ex	aminer: On the	he best of my basis of exam inner stated.	knowledge, on nination and/	death occurre or investigation	ed at the tin on, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
	To the within 2 To the comple	M	29b. Signature and	tive of certifier				2	9c. Licens	e number	9	29d. Date sig		
			120	S	reloz	-	A NE		<u></u>	4214	1	TILA	1 31	.3006
	1,9		30 Name and add	ess of person who	o completed ca	ula diath ((Item 23a) (T	(pe, Print)	el &	Fire	Gl-ei	- bus	me m	9006
-5	Sta Registr		31. Date filed (Mon		106 A	Registrar's Si	ignature	Corte	,		(

				For State Registrar	State of	of Marylar		artment of F	lealth and I Death	Mental Hy	/giene Reg. No	2006	17057
				1. Decedent's Name (First, Middle	, Last)					2. Date of D			3. Time of Death
_		Physici		Winginia		1	Lith i mma			Month	27, ^{Da}	2006 Year	5:15A M
		/Medic Examin		Virginia 4a. Facility Name (If not institution	, give street and nu	mber)	Whippo	4b. City, Town, o	or Location of Death			c. County of Deat	
•	1	Examin	ici	Gilchrist Hos	nice			Tows	on			Baltimor	re
		Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B			hplace (State or Foreign untry)
		Director		211 02 2074	1□M 2√F	87	Yrs.	Months Days	Hours Min.	June 3	. 191	8 Penr	nsylvania
				211-03-2074 Usual Residence of Decedent									
		nylan how		10a. State 10b. County		10c. Ci	ty, Town or Lo						10d. Inside City Limits
		a-1 s	cto	Maryland Baltir	nore		Tows	son					1 ☐ Yes 2 ☐ No
		or 26	Directo	10e. Street and Number				10f. Zip Code				itizen of What Co	
		hours after deeth with the Maryland tural, or iteme 23a or 28a-f show all Examinat must be notified at		7925 York Road				2120				ited Sta	
		teme	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, White	
	36	ori	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve		1 ☐ Yes 2 🂢 No	Specify:			Specify: Wh	nite
	Ş	hour tural	Pe	15. Decedent	Year or E	Jales.	16a Dece	dent's Usual Occur	nation		16h k	Kind of Business/	Industry
	15	in 72 "na ledic	Completed	(Specify only highes	st grade completed)		(Give		during most of wor	rking	100.1	tilla of Baointooa	
	112	with ene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker				Own Home	
_	D	1 be filed within 72 hatal Hygiene. ed other than "nate: event, It a Medical		17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle			
3	an	id be iental ked ic ev	To Be	Clayton Eberso	ole				Ida	Davis			
:15am	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Examinet must be notified at ance.	-	19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numi	ber, City	or Town, State, Z	(ip Code)
	Ž	and 2 Balth a n 27 is		Carol J. Whippo	o, Daughte	er	40 Mea	adow Run	Court, S	parks, I	MD 2	1152	
5	ē,	s 1 a f Hear item othe		20a. Method of Disposition		20b. I		osition (Name of matory or other pla		Date	_	ocation - City or	Town, State
	E	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S					ardens 6/05	5/06	Timo	nium, Mary	vland
	alti	mit. partm porta porta / Inju		21. Signature of Furnaral Service	licensee				-				Services of
	Ö	89 8 8		SWOT KSTO	W-	M011	13 D	ılaney Vallı	ey, P.A. 20	00 Padonia	a Road	d, Timoniu	m, MD 21093
				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition			· Itec	14 faile	re				Onset and Death WCCKS
	4	/Medical		resulting in death)	a. Due to	(or as a consec	quence of):	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7					
		Examiner		Conventially list conditions	b Le	na M	na lign	ancy					Years
60		DV =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or Ma a consec	mence of):						
20		nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
90/6	, 0,	ate be executed ysician and he burial-transit	ũ	resulting in death) Last	Due to	(or as a consec	quence of):						
7	Box 68760,	at you	licai		d.	_				_		_	
5	9	leath certifica attending ph I for use as ti	Physician/Med	IF FEMALE:	222 16.122 21								
	90	ath o	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregn birth 2 Teta	al death 3[Ectopic pregnanc	у		1	23d. Date of deli Month	very Day Year
		the a	/sic	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟Unkr	nant at time of one of the community of	death 5	Other (specify)					
	P.O.	that the de led by the a detached f		Part II. Other significant condition	ons contributing to a	feath but not res	sulting in the u	indertving cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
. 3	Records,	signed by	d by		•		3	, , , , , , , , ,		1 🗆	Yes 2	No 3□Pro	obably 4 Minknown
ginia	Ö	v requir been si should	Completed							240 1460		Odb Word ou	taray findinga ayaylahla
8	3ec	has has l	Ig II							24a. Wa auto	opsy formed?	prior to death?	topsy findings available completion of cause of
	<u>e</u>									1 □ Yes	2 S No		2 No
>	Vital	ysician: is certific director.	Be	25. Was case referred to medical examiner?	Hospital:			O#	26. Place of Dea				Horace
0	o	ding Phys	J.	1 Yes 2 Mo			ER/Outpatier 28b. Time o	nt 3 DOA	ner: 4 ☐ Nursing H	lome 5 ☐ Res 28d. Describe			city) / /USP/CE
po	On	ding Ph h. After th funeral	ti E	1 Natural 5 ☐ Pendin	3	of Injury oth, Day Year)	Injury	Wo	rk? Yes 2 □ No			,	
Jhippo	Division	i or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - At h	nome, farm, st	reet, factory, office					ral Route Number,
5	Div	after of Direct	erti	4 Homicide	build	ling, etc. (Speci	fy)			City or To	own, Stat	'e)	
3		spita nours norai	aic		ng Physician: To th								
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	(Check only 2 Medical one)	Examinar: On the tand man	pasis of examination of stated.	ation and/or in	vestigation, in my	opinion, death occu	irred at the time	, date an	od place, and due	to the cause(s)
		To the To the Comp	ž	29b. Signature and title of certifie	///			29c. Licens				ate signed (Month	
		/		180 (81	ack MI)			061199			lay, 27,	1006
		15		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print) 6601	N. CHA				
		10		Jason Black				70	WSON,		212		
			ate	31. Date filed (Month, Day, Year)	32. 1	Registrar's Sign	ature	e e	•				
		Regist	rar	MAY 3 1 7 111	D KARAGA	NO.	19	100					

			4 101	partment of Health and Nertificate of Death		iene	17058
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ruth E. Wickless		2. Date of Deat Month May	the Car Car Car	3. Time of Death 1:30 pm M
	Examin	er	4a. Facility Name (If not institution, give street and number) Continuum Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Sykesville (1) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Carrol	
	Funeral Director		216-14-7446 1□M 217 90 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day April	3, 1916 MI	place (State or Foreign htry)
	he Marylan 18e-f show outlied at	Director		ville	1		0d. Inside City Limits 1 Yes 2 No
	ath with t	rai Dir	10e. Street and Number 7309 Second Avenue	10f. Zip Code 21784		0g. Citizen of What Cou	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "netural; or items 23a or 28a-f show aumatic event, the Medical Examinar must be notitled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married It Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Bleck, White, Specify: Wh	
Maryland 21215-0036	within 72 ho ane. Ihan "netur ie Wedical	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Homemaker	ing	16b. Kind of Business/In	
land 5	uld be filled v fental Hygie rked other i tic event, L	To Be Co	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name Unknown	e (First, Middle, M	Domesti Maiden Sumame)	<u>C</u>
, Mary	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic a <u>once</u> .		Mrs. Lili Kaufman (Granddaugher) 71	ling Address <i>(Street and Number or Run</i> 53 Wimmer Lane Syk	esville,	MD 21784	
altimore,	t. Pages 1 rtment of H rtent: if ite njury or oth		1 □ Burial 2x □ Cremation 3 □ Removal from State 14 □ Donation 5 □ Other (Specify) A11 Cou	ematory or other place) nty Cremation 5/30	0/06	20c. Location - City or To Sykesville,	MD
Ba	permi Depa Impo any ii		- Gunt Cray	AAIGHT FUNERAL HOM Sykesville, MD 2178	34 (410)	793-1400	195)
8760,	The law requires that the death certificate be executed with the death certificate be executed with a possible to the latter than the latter t	dicai Examiner	23a. Part1. Enter the disease, or complications that laused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	may Fibrillat			Interval Between Onset and Death
.O. Box 6	that the death certific ed by the attending p detached for use as i	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to thes 2 \(\text{No} \) 3 \(\text{Prob} \)	
		Completed			24a. Was ar autops perform 1 = Yes 2	24b. Were auto prior to cor death? 1 Yes	psy findings available inpletion of cause of 2 No
Vital	ysiclar s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ MO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	26. Place of Death ent 3 DOA Other: 4 D Nursing Ho		e) ance 6 Other (Specifi	()
Division of	Attending Physician: r death. sctor: After this certifici	ation: T	27. Manner of Ceath 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at		w injury occurred	,
Divi		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town		
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, da	ate and place, and due to	the cause(s)
i			29b. Signatura and till of certifier Chause M	D -00542		od. Date signed (Month, of Society) Months, MD	
	.7			nalesm dure,	Wenn	nuty MD	2/157
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signaturé	rack s			

		•	For State Registrar	State of M	laryland /	-	artment of H		ınd M		iene	06	17059
	n Division		1. Decedent's Name (First, Middle, La	st)						2. Date of Deat Month	Day	Year	3. Time of Death
1	Physicia /Medic	al	Karen Sue Ambro							May		006	3:20 p ^M
7	Examin	er	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of minst			4c. County	of Death Carro	
144			65 Smith Avenue 5. Social Security Number 6. S	Sex 7. A	ge (In yrs. last b	oirthdav)	If Under 1 Year	If Under 2		8. Date of Birth			place (State or Foreign
200	Funeral Director			1 □ M 2 🔀 F	43	Yrs.	Months Days	Hours	Min.	March 2	8°1963	Соц	ntry) MD
344	p		Usual Residence of Decedent		10. Oit. T.								104 India Challen
	arylar show	_	10a. State 10b. County MD Carro	51.1	10c. City, To		tminster						10d. Inside City Limits 1 ☐ Yes 2 XNo
	he Mi	ecto				111-11	10f. Zip Code			11	og. Citizen of	What Cou	
	with t	Funeral Director	10e. Street and Number 65 Smith Aver	1110				157		, ,	•	SA	inty:
	na 23	era	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.1	Was Decedent of His f Yes, specify Cubar		gin? (Spe	cify Yes or No-	14. Rad	e - Ameri	can Indian,
9	or ite	교	1 Never Married 2 Married	Armed Forces 1 Tes 2			1 Yes, specify Cubar 1 □ Yes 2XX No	Specify:	, Риепо і	Hican, etc.)	Specif	ck, White. Wh	nite
203	72 hours after death with the Maryland natural; or itema 23a or 28a-f show deat Evanta at must be collified at	d by	3 Widowed 4 Divorced	Year or Dates:									
15-	"nati	iete	15. Decedent's E (Specify only highest gr		- 16	ia. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired;	ition <i>uring most</i>	of working	20	16b. Kind of B Reed at		•
12	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		f Financi				Elec I		
שַ	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or liema 23a or 28a-f show of other than "natural", or liema 23a or 28a-f show ovent, the Madical Evant are must be notified at	BeC	17. Father's Name (First, Middle, Last	")				18. Mother	r's Name	(First, Middle, N	faiden Sumar	ne)	
ylar	should be nd Mental marked o	To	William L. Ambro	se					101				
Maryland 21215-0036	d 2 :		Jeff Scott Stoner				ng Address (Street a mith Aven					State, Zi _i 1157	o Code)
	s 1 an f Heal Item 2 other		20a. Method of Disposition		ceme	of Dispo	sition (Name of matory or other place	9)	D	ate	20c. Location	- City or T	own, State
E	Page nent c ant: If ary or		1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				remation,		5/16	/2006	Hamps	tead,	, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other QDGE.		21. Signature of Pheral Service Lice	nsee 2			ritts fun 12 Washin						21157
¥.			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause	ed the death. De								Approximate Interval Between
k.,	Physician		Immediate Cause (Final disease or condition	Mez-	tastati	16	birecut	CEHC	42				Onset and Death
ST ST	/Medical Examiner		resulting in death)	Due to (or a	s a consequenc	e of):							
e de la companya de l	Examine.	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequenc	e of):							
	uted f insit	Examiner	Cause (Disease or injury			,							
o	exect an and rial-tra		that initiated events resulting in death) Last	Due to (or a	s a consequenc	e of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	icai	•	d									
9	death certifica attending ph d for use as th	Physician/Med	IF FEMALE:	20. 16									
Вох	attend attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		e or pregnancy 2 ☐ Fetal dea at time of death		Ectopic pregnancy Other (specify)					te of deliventh	ery Day Year
P.O.	that the de led by the a detached t	iysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9☐ Unknown	at taile of death	56							
	res that signed b be deta	by Pt	Part II. Other significant conditions			g in the u	nderlying cause give	n in Part I.		23e. Did tob	acco use con	tribute to	the cause of death?
rds	w require been sig should b			one Ku	644					1 ☐ Ye	s 2 🗆 No	3 Pro	bably 4 Nhknown
of Vital Records,	e law requ has been je 2 shoul	Completed								24a. Was ar	y	prior to co	opsy findings available ompletion of cause of
= =		Con								perform		death?	2 🗆 No
Vita	Physician: The this certificate rat director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only on			
of	Phys	. To	1 Yes 2 No 27. Manner of Death	i l linpai	tient 2 ER/	Outpatie	IL 3L DOA	4 🗀 Nui		me 5 Reside			fy)
on	Attending For death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	f 28c. Injury Work	:? Yes 2 □ N	No				
Division	Attendi ar death. ector: A by the fu	Certification:	3 Suicide 6 Could not determined	289. Place of I	njury - At home, atc. (Specify)	farm, st	reet, factory, office		2	281. Location (St. City or Town		oer or Rur	al Route Number,
Ö	ital or urs afte ral Dir lled in												
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical		hysicien: To the bes miner: On the basis and manner:	of examination								
	To the within 2 To the complei	Me	29b. Signature and title of certifier				29c. License			29	9d. Date signe		
)	MIL		Howard So	wont, in	.D.		015	5552			5/1	6/-(
	20		30. Name and address of person who	+ 2 m. D.	555 9.	Cz	ムナマレ ジナ	トキモク	4	Suptem in	ンプペリ	m d	21157
100	Sta Regist		31. Date filed (Month, Day, Year) MAY 16	2006 32. Pagis	trar's Signature		lack o						
* >	war all			1		_/3							

06-03160 Kathryn S. Allen

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifi	cate of	Death			Re	g No.	UUb	1/06
Physicia	an/	1. Decedent's Name (First, Middl	e,Last)			· · · · · · · · · · · · · · · · · · ·			Date of Death	n		Time of Death
ledical Exami	ner	KATHRYN ANNE	S. ALLEN						Month May 10, 20	Day Yea) 06	r 1	1210 hrs
		4a. Facility Name (if not institution	· -		41	c. City, Town, or	Location of	of Death		4c. County of	of Death	
		University Hospital-Sh	nock Trauma			Baltimore						
Funeral		Social Security Number	6. Sex 7. Age	(In yrs. last b	irthday)	If Under 1 Yea			B Date of Birtl	h(MM/DD/YYYY		ice (State or
Director		218-52-8181	1 M 2 X F	58	Yrs	Months Day	s Hours	Min.	02/14/	1948	Foreign Country	() DC
	H	Usual Residence of Decedent							02/14/	1740		, DO
any	- 1	10a. State 10b. County	T	10c. City, Tow	vn or Locatio	n					10d	d. Inside City Limits
d 6.		MD OTHERN	ANNE'S	CENTE	DEVITT	T.					1 [Yes 2 X No
Maryland 28a-f show any <u>1 at once.</u>	흕	MD QUEEN 10e. Street and Number	ANNE 5	CENT.	REVILL	10f. Zip Code			110	g. Citizen of Wh		
Mai r 28	Director	roo. On oor and reampor							1'0	g. Onizen or vvii	at Country?	
th the Maryland 23a or 28a-f sho notified at once.	의	104 QUAIL LANE				21617				USA		
th wi	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent E arried Armed Forces?	Ever in U.S.		Decedent of His s, specify Cubar				14. Race White		Indian, Black,
or it	μ		1 Yes 2	X No								
afte ral",	à		orced If Yes, Give Year or Dates:			Yes 2 X No				Specify:	WHITE	\$
5-0036 led within 72 hours a Hygiene other than "natural the Medical Examin		15. Decedent's Education (Spe				s Usual Dccupat st of working life				16b. Kind of Bu	siness/Indus	itry
6 1,72 l	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	·					<i>'</i>			
vithir ene er th	Ē	12	4	F	REELAN	ICE WRIT	ER			PUBLIC	ATION	
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	ပ	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (Fi	rst, Middle, M	aiden Surname)	,	
be fi mrtal rrked	Be	PRINT EDWARD S	HOMETTE				LUCY	GOET	rz			
21 nould id Mei is mai	2	19a Informant's Name/Relations	hip (Type, Print)	1	19b. Mailing	Address (Stree	et and Num	ber or Rura	al Route Numb	per, City or Town	n, State, Zip	Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.		IAN ALLEN / SO	N		6349 R	EDWINGE	D BLA	CKBIF	RD DR.,	WARREN	TON, V	VA 20187
	- 1	20a Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from Sta	20b. Place	e of Dispositi atory or other	ion (Name of cer	metery,	D	ate	20c. Location -	City or Town	n, State
MOre Pages 1. nent of H ant: If it		4 Donation 5 Other SA		" CHESA	APEAKE	CREMAT	ION	05/12	/2006	STEVEN	CUTITE	7 MD
Baltimore, Permit. Pages I an Department of He Important: If ite		21. Signature of Funeral Service		CENT	22. Na	me and Address	s of Eacility	,				
Baltimore permit. Pages 1 Department of F Important: If injury or other		Clardo	+ 500		FEL	LOWS, H	ELFEN	BEIN	& NEWN	AM FUNE	RAL	OME, P.A.
Physician	\neg	23a. Part I. Enter the disease, or		he death. Do	not enter the	mode of dying,	such as ca	ardiac or re	spiratory arre	st, shock, or hea		oproximate Interval
/Medical	- I	failure. List only one cause	0 4 -1 0 -1	· Mound o	f Uood						Be	etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Gunsho Due to (or as a conse		пнеао						-	Death
8		0 11 11 11 11 11 11 11	b	4401100 01).								
	뉼	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c									
sit.	×a	events resulting in death) Last	Due to (or as a conse	quence of):								
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760, icate be ex physician the burial	n/Medical	UNPENDED	AMENDED									
8760, tificate by ng physic as the bur	ğ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom			. 1				23d. Date of		
68 certif nding se as	ian	past 12 months?	1 Live birth 1 Pregnant at t		2 Feta		Ectopic	pregnancy	,	Month	Day	Year
Box e death c the atten	/sic	1 Yes 2 V No 9 Uni	known 9 Unknown	01 404.1	5 Othe	er (Specify)						43
that the death certificate by the attending detached for use as	Physicia	Part II. Other significant condit		but not result	ing in the un	derlying cause o	given in Pa	rt I.	23e Did tob	pacco use contrib	oute to the cr	ause of death?
rds, P.O. requires that the bear signed by should be detach	ρ				J		•		1 Yes	2 V No 3	Probably	4 Unknown
S, quire en sig	Completed								24a Wasar			/ findings available
ords, aw requir as been s 2 should	읦								autops	у рі	rior to comple	etion of cause of
tal Reco cian: The law certificate has	[E								perform 1 Yes 2		eath? Yes	2 No
an: an: tror,	ادہ	25. Was case referred to medica						(Check only	one)			
Vita ysici direc	œ o	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	t 2 ER/	Outpatient	3 DOA	Other 4	Nursing H	ome 5 R	tesidence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requir is after death al Director: After this certificate has been seled in by the funeral director, page 2 should it.		27. Manner of Death	28a. Date of Injur	y 28t	o. Time of Inj	ury 28c. Inju	ry at Work			w injury occurre	d	
endin	恴	1 Natural 5 Pend		10	20 hrs	1 1	Yes 2 🗸	No Su	bject shot	self		
ivisior or Attend after death Director:	ica		stigation28e. Place of Inju	ury - At home,	farm, street,	factory, office b	uilding, etc	c. 28t	f. Location (St	reet and Numbe	r or Rural Ro	oute Number, City
Divi	Certification:		d not be (Specify) Bac	k vard					or Town, Sta	^{ate)} ne, Centrevi		
		29a. Certifier	hysician: To the best of my		leath occurre	ed at the time de	ate and nla				-	
To the Howithin 24 h To the Fur	Medical	,	miner:On the basis of exam									ise(s)
To To con	Mec	29b Signature and title of certifie	and manner stated.			29c. Licens	e number			29d Date signe	d (Month D	Day Year)
		1 / 2	0. 415			O.C.1			l l	May 11, 200		
		au	usern	,			* 4 : how :			ay 11, 200		
1 /		30. Name and address of person				Stroot Delti-	nore in	D 24204				0
Lekk			ssistant Medical Exa		enn	Street, Baltin	וטו פ, IVII	₩ Z 1ZU I				
St Regis	tate	31. Date filed (Morth Ay, Year)	2 2006 ^{32. Registrar}	s Signature	los	all s						
4000			7		1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 16 Day Mildred Viola Abrams May 2006 7:14 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6200 Westchester Park Drive #412 College Park Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 4. Month Day. | Jan 22, 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 002-05-9654 Months 1 ☐ M 2 🔀 F 1908 98 Massachusetts Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Mudical Examiner must be notified at 1X Yes 2 □ No Maryland Prince George's Director College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 20740 6200 Westchester Park Drive #412 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates: neturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than 'eny injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Thompson Bernice Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thompson (Nephew) 10105 Marguerita Avenue, Glenn Dale, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 5/20/2006 ¹ 4 □ Donation 5 □ Other (Specify) Brentwood, MD eral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature 9013 Annapolis Road, Lanham MD 20706 23a. P. at. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only an eause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final disease or condition resulting in death) Hy ber tensive Cardiovascular Disease Enysician /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diae to (or as a consecuence of Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the the 9□ Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Congestive Hear 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medicai Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 T Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitei within 24 hours a To the Funerel C certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05-18-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashai, M.D. 4410 74th Avenue, Landover Hills, MD 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2006 Registrar

		1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F		Mental Hy	ygiene	06 17062
		1. Decedent's Name (First, Middle, La	st)				2. Date of D	eath	3. Time of Death
Phys		Carlardo Udill	iams Avery				Month May	Day 14	Year 2006 10:50 A ^M
	dical niner	A F and Manager of and to the state of			4b. City, Town, o	r Location of Death	May	4c. County	
		Southern Mary	land Hospit	tal		Clinton		Pri	ince George's
Funer		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	Birthplace (State or Foreign Country)
Directo	or	128-30-2024	I □ M 2 🕅 F	66 Yrs.	Months Days	TIOUTS INTE		2, 1939	West Virginia
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				
taryla	7			700. Ony, 10m1 of 2.	Joan				10d. Inside City Limits 1 XYes 2 No
the N 28a-f	Director	Maryland Prince	George's			rt Washi	ngton	40.00	
with	급	COOC A 1 T			10f. Zip Code	00744		10g. Citizen of \	What Country?
eeth Tare	era	8306 Arden Lan	e 12. Was Decedent Ev	ver in IIS 13	Was Decedent of H	20744	acifu Vac or N		ed States
laryland 21215-0036 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "natural", or itema 23a or 28a-f ahow aumatic event, the Medical Examinar must be notified.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Tribivorced	Armed Forces? 1 Yes 2 No		If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Blac Specify	ce - American Indian, ck, White, etc.
21215-0036 d within 72 hours afl giene. or then "natural", or the Medical Exam	pa	15. Decedent's E	Year or Dates:		dent's Usual Occup	ation		Lach Kind of D	
15 in 72	Completed	(Specify only highest gra	ide completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of Bi	usiness/Industry
with the same of t	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+	.)		" ition Tead	- I	MD 0	
THOO HE	BeC	17. Father's Name (First, Middle, Last,)	spec	Tal Equea	18. Mother's Name			Government
Maryland 2: d 2 should be filed v th and Mental Hygie t7 is marked other t traumatic event. III	To B	Joshua O. W	illiams. Sr	• •			Δαn	es Palle	mon
shound M		19a. Informant's Name/Relationship (ng Address (Street a	and Number or Rura			
M2 Jd 2 27 is		Patrick Avery/	Son			Lane, Ft.			
THE THE		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date		City or Town, State
Baltimore, Marylar permit. Pages I and 2 should be Deperment of Health and Menta Important: if Item 27 is marked any injury or other traumatic ex		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			natory or other plac Memorial	Cem. 5/19	/2006	Suit	land, MD
mit. I sertm	<u></u>	21. Signature of Funeral Service Licer			. Name and Addres			Funeral	
n gget	ă	John T. S	tewart 11		4001 B	enning Ro			
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	he death. Do not ent					Approximate
Physicia	n	Immediate Cause (Final		scle notic	Candine	501 L D			Interval Between Onset and Death
/Medica		disease or condition resulting in death)		consequence of):	Carcaro	evicuen V	isea le		54.
Examine	r	water consequence and remark and		, , , , , , , , , , , , , , , , , , , ,					
	Je L	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
cuted	Examin	Cause (Disease or injury that initiated events	С.						
O, exe		resulting in death) Last	Due to (or as a	consequence of):					
SK/6U, icate be executed physician and it the burial-transit	dicai		d						
ng pt	Med	IF FEMALE:							
Geath certifice attending a	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy				e of delivery
. 0 00	S	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at tir 9☐Unknown		Other (specify)			Mon	nth Day Year
ords, P.C. requires that the desensigned by the should be detached?	ڄ	9 Unknown							
S, T res that igned t be det	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contr	ribute to the cause of death?
ecords, law requires t as been signe 2 should be (ted						10	Yes 2□No	3 Probably 4 Kr Unknown
S S S S	Completed						24a. Was		Vere autopsy findings available irior to completion of cause of
ate page	000						perfo	ormed? d	leath?
VITAL LICIAN: Certifical rector, p	Be (25. Was case referred to medical examiner?				26. Place of Death	720 200		
— ≥ ∞ P	ပ	1 ☐ Yes 2 ₹ No	Hospital: 1 1 Inpatient	2 ER/Outpatien	t 3□ DOA Othe	ar: 4 🗆 Nursing Hor	ne 5 🗆 Resi	dence 6 □Othe	ar (Specify)
		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day)	28b. Time of Injury	28c. Injury Work			how injury occurre	
DIVISION or Attanding effer death. Diractor: After in by the fune	ertification:	2 Accident investigation				res 2□No			
or Attan effer deat Diractor: in by the	Ę	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	et, factory, office		28f. Location (: City or Tox	Street and Numbe	er or Rural Route Number,
pital o ours of narei D	O								
A Hospital of 24 hours ere Funarei Dietely filled i	edical	Check only 2 Medical Exam	ysician: To the best of minor. On the basis of each	my knowledge, death	occurred at the tim	e, date and place, a	and due to the	cause(s) and man	ner as stated.
To tha within 2 To the complet	Med		and manner state	d.					
C S S S	~	29b. Signature and title of certifier			29c. License				(Month, Day, Year)
To		m Sida-	_			5365		21-20	- 2006
218/		30. Name and address of person who						м.	/
		Michael Sidaron	1170 1170	1 /16 ings	tage Pil 6	t 10 / ++ 0	VARLY	a rip	20744
S Regis	State	31. Date filed (Month, Day, Year) MAY 1 8 2001	Hegistrar's	s signature	100		,		
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment of H				giene Reg. No.	2006	17063
	Dharaisi	ð-	1. Decedent's Name (First, Middle	Last)						2. Date of De Month	aath Day	Year	3. Time of Death
	Physici /Medic		MISH	AEIL		ASHOU				May	13,	2006	
1	Examin	er	4a. Facility Name (If not institution,	give street and numb	oer)		4b. City, Town, or		of Death			County of Deatl	
			Frederick Mer				Freder If Under 1 Year	ick If Under	24 Hrs.			rederi	
	Funeral			6. Sex 7. 1 X M 2 ☐ F	Age (In yrs. I	Yrs.	Months Days	Hours	Min.	B. Date of Bir (Month, Da	ay, Year)		nplace (State or Foreign untry)
si ^{nt}	Director		220-11-3883 Usual Residence of Decedent		_73				I A	ug. 29	9, 19	32 Ira	n
	yland low		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Man Lied	to	Maryland Freder	ick	I	rederi	ck						1 □ Yes 2 🔀 No
	n 188	Directo	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
	th wil	alD	4874 McLauren C	ourt			217	03				Iran	
	or Items	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U. es?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Or n, Mexicai	igin? (Spec	rify Yes or No	D- 14	4. Race - Ame Black, White	
36	or It	F.	1 Never Married 2 Marri	If Yes, Give			I □ Yes 2 🗓 No	Specify:			3	Specify:	
21215-0036	within 72 hours after death with the Maryland ane. sne. then "natural", or Items 23e or 28e-f ehow the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Date	9S:	100 0						Wr	ite
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12	withii ene. then	m C	Elementary/Secondary (0-12)	College (1-4	or 5+)		ine Opera				Priv	ate In	dustrv
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an	id be ental ked o	To Be	Eshu Ashouri	an				К	hava	Nissa	an		
Maryland	should Ind Men marke		19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street a					Town, State, 2	ip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at		Nadia Ashouria	n - Wife		4874	McLaure	n Cou	ırt, E	rederi	ick, 1	Marylan	d 21703
J.G	of Heal		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other plac		Da			ation - City or	
Ĕ	Pages 1 an ment of Heal ant: If Item 2 ury or other		1 Burial 2 Cremation 4 Donation			e of F	leaven Cer	meter	y 5/1	8/06	Silve	er Spri	ng, Marylan
Baltimore,	permit. Pages Department of Important: If II eny injury or c		21. Signatule of Funeral Service L	gensee Will	inm) M	Name and Address Noleswort 16401 Rid	h-Wil	liams	P.A.,	Fune	eral Ho Marvlan	me d 20872
4k	i i		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death	h. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory a	rrest,	3	Approximate Interval Between
):	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. N	as a consequ	1.	Gastn	۲ (Can ce				Onset and Death
*	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	uence of):		<u> </u>					
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to /or	r as a consequ	uanca of):							
8760,	be ex cian burial			Due to (or	43 4 CO113641	derice ory.							
87	physicate physicate	edical		d									
P.O. Box 6	that the death certificated by the attending placed for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal nt at time of de	Ideath 3□	Ectopic pregnancy Other (specify)				23	3d. Date of deli Month	very Day Year
	res that igned to be deta	by P	Part II. Other significant condition			ulting in the u	nderlying cause give	en in Part i	l.	23e. Did 1	tobacco us	e contribute to	the cause of death?
rds	w require been sig should b	D D	Resp. mtory	trilor	1, \$					1 🗆	Yes 2□	No 3□Pro	obably 4 Junknown
Records,	law requires that the as been signed by th 2 should be detache	Completed	Rospimtory Hypokusio	N						24a. Was		24b. Were au	topsy findings available
Re	0 - 0	E o	1		· · · · · · · · · · · · · · · · · · ·					auto perfo	omed?	death?	ompletion of cause of 2 No
ta	ician: Th certificate ector, pag	0	25. Was case referred to medicat					26. Place	e of Death	(Check only			-2
2		To B	examiner?	Hospital:	patient 2	ER/Outpatier	t 3 DOA Othe	er: 4 🗆 Ni	ursing Hom	e 5□Resi	idence 6	□Other (Spec	uty)
0	ig Ph ter th neral		27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time of Injury	28c. Injury Work	/ at	21	Bd. Describe	how injury	occurred	
joi	Attending ir death. ector: After by the fune	atic	1 Matural 5 ☐ Pending 2 ☐ Accident investig	ation		,		Yes 2 □	No				
Division of Vital	i i i i	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	nod 286. Place o	f Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office		21	Bf. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 Certifyin (Check only one) 1 Medical	Physician: To the be examiner: On the bas and manne	is of examina	wledge, death tion and/or in	occurred at the time vestigation, in my of	ne, date ar pinion, dea	nd place, ar ath occurre	nd due to the d at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To ti Withi. To ti	Ň	29b. Signature and the of certifier				29c. License	e number			29d. Date	signed (Month	n, Day, Year)
			tennie	I. Inzak			0-	5779	16		5-	- 14-0	6
	15		30. Name and address of person	who completed cause	of death (Item	п 23а) (Туре,							
	15		Ronnie L. J				7th Stree	t, Fi	reder:	ick, M	ary1a	nd 217	701
, , ¢	Sta		31 Date filed (Month Day Year)	32 Bay	rietrar's Signa	tura							
			MAY 1	8 2006	en.	K A	soul!					·	
DH	Registrar MAY 1 8 2006 Seem MAY 1 8 2006												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10e 20c per fh 8856 6-1-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Blumenstock 1853M Kenneth A 0.5 15 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** River Hospital 21620 hestertownMod Chester CRMI If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Min Months Hours 078-30-6201 1 3 M 2 □ F 68 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a State 10h County rthen "natural", or items 23a or 28a-f ehow the Madical Examinar must be notified at 1 ☐ Yes 2 No STEUBEN HAMMONDSPORT NV Director 10e. Street and Number ROUTE 10f. Zip Code 10g. Citizen of What Country? USA STATE 12934 2010-54 14840 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 (MayYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Colfege (1-4or 5+) is marked other then Elementary/Secondary (0-12) ADMINISTRATOR HEALTH CARE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny july or other traumatic event ONG. Be BLUMENSTOCK WILMA ABEL MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) 12934 STATE ROUTE 54, HAMMONDSPORT MARTHA BLUMENSTOCK/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Hammondsportown, State 20a. Method of Disposition PLESANT VALLEY OF 120/06 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS HILL OPENBEIN NEWNAM PUNETRAL 21. Signature of Funeral Service Licensee KickS 130 SPEER RD CHESTEDTOWN MD 21670 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Approximate interval Between Onset and Death Immediate Cause (Final SANDIM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai the attending p IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? Month Year 5 Other (specify) ed by the all detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No sete has t page 2 s certificete 1 Yes 2 No Attending Physiclan: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ierel Director: After this filled in by the funeral dis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No death. investigation s efter death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funerel C 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certain 29c. License number 29d. Date signed (Month, Day, Year) am Zeemey (12) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRAMOR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 200 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 03:00 AM Wesla /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Age (In yrs. iast birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours -862 1 XM 2□ F Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Ken Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ev.
Amed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary College (1-4or 5+) abor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2006) 20b. Place of Disposition (Name of cemetery, crematory or other) 5 18 2006 20c. Location - City or Town, S- te 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State ö Dept. rtment i Importent: If any injury of once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WOLLON P rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line respiratory arrest. or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit Chrome Acchelis IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital Hospitel or Attending Physician:

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

28s-f show

or Itams 23a or

"natural",

I Hygiene.

it. Pages 1 and 2 should be furment of Health and Mental Intent: If item 27 is marked o

Be Completed by page 2 should funeral director, Certification: To

to BACCO ABUSE

1 Inpatient

24a. Was an autopsy 1 ☐ Yes 2 7 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner' 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 28b. Time of Injury

3 DOA 28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Natural

2 Accident

3 Suicide

4 - Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifier

29c. License number 23889 29d. Date signed (Month, Day, Year)

completed caus of death (Item 23a) (Type, Print) ARRABAL Mr. John C.

Hospital

223 1tigh Street, CHester Form, Ned 21620

State Registrar

To the Hospital within 24 hours a To the Funeral completely filled

2)

Medical

31. Date filed (Month, Day, Year)

MAY 1 8 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended \$6,5/23/06, M.S., Kent Co.

1- Stata
Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Barr eral Mai d 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner iver 6 8. Date of Birth (Month, Day, Year) 02/19/1943 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** Days Hours Min 213-42-0920 63 D.C. Director х(м) Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other then "natural", or iteme 23a or 28a-f show vent, the Medical Examinar must be notified at MD KENT ROCK HALL 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6435 ROCK HALL ROAD 21661 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a eny injury or other traumatic event. The Madical Examinat mubil once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ELECTRICIAN ELECTRICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ERIC BARRY EDITH WALDERN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY JANE BARRY/WIFE P.O. BOX 591, ROCK HALL, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 05/18/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUENRAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Euneral Service Licensee uk 23a. Part1. Enter the disease, or complications that caused the death, so not ever the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. nd Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Unknown 1 ☐ Yes 2 ☐ No 3 Probably has been signed to should to Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops certificete 1 ☐ Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 Other: ို 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the fail or of D 28a. D te D te of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 🗌 Yes 2 🗌 No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L filled 29a. Certifier * Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical] Me 🖆 Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. il e 29d. Date signed (Month, Day, Year) 29b. Signatury and title of certifier 0 Name and ad 30 person who co f death (Item 23a) (Type, Print) MS

DHMH 17 Rev 1/2001

State Registrar

Month, Day, Year)

32. Regis

2006

Am	ended#	10a	,05/26/06,MS,Kent Ostate	of Maryland / Depa	artment of Health and Natificate of Death	lental Hygi	ene,2006	17067
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) SARAH ANN ERVIN BECK 4a. Facility Name (If not institution, give street and not also be added to the street and not also be added t		4b. City, Town, or Location of Death WORTON	MAY 19	Day Vone	3. Time of Death 03:30 A M
	Funeral Director		5. Social Security Number 201-22-1594 6. Sex 1	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, MAY 25,		place (State or Foreign ntry) PA
	the Maryland 28a-f chow	Director	10a. State 10b. County PA: MD KENT 10e. Street and Number	10c. City, Town or Lo		10	ng. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
96	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "naturel", or iteme 23a or 28a-f ehow other traumatic event, it a Medical Examinar must be notified at	by Funeral Di	Armed I 1 □ Never Married 2 Married 1 □ Yes	cedent Ever in U.S. 13. Forces?	21678 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, Specify: WH1	etc.
121	I within 72 hours lene. r then "naturel". In Medical Exi	Completed b	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired) HOMEMAKER	ing 1	6b. Kind of Business/In	
Maryland 2	ould be filed Mental Hygi Marked other latic event, I	To Be C	17. Father's Name (First, Middle, Last) HARRY THOMAS ERVIN			HINE CER	VINO	
re, Mar	s 1 and 2 sho of Health and item 27 ie m other traum		19a. Informant's Name/Relationship (Type, Print) JAMES BECK/HUSBAND 20a. Method of Disposition	2498 20b. Place of Dispo	ng Address (Street and Number or Run B6 MONTABELLO LAKE ssition (Name of matory or other place)	ROAD, W		21678
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is eny injury or other tra ance.		1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	CHESAPEAR	CE CREMATION 05/2 2. Name and Address of Facility FELLOWS HELFENBE 130 SPEER ROAD, C			
60,	Physician (Medical Examiner prius) prius p	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	each line.		or respiratory arre	st,	Approximate Interval Between Onset and Death
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	e law requires has been sign e 2 should be	Completed by Physician/Medi	Part II. Other significant conditions contributing to	4	1 1	23e. Did tob 1 Ye. 24a. Was ar autopsy perform 1 Yes 2	24b. Were auto prior to co death?	pably 4 Junknown
on of Vital	ding Physician:). After this certifica funeral director, p	Certification: To Be C	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be detailed.	Inpatient 2 ER/Outpaties e of Injury nth, Day Year) 28b. Time o Injury ce of Injury - At home, farm, st ding, etc. (Specify)	f 28c. Injury at Work? M 1 Yes 2 No	me 5 Aesider 28d. Describe ho	nce 6 Other (Special winjury occurred eet and Number or Rure	(y)
_	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical Ce	(Check only one) 2 Medical Exeminer: On the and ma	basis of examination and/or in inner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occurred. 29c. License number	ed at the time, da	te and place, and due to	Day, Year)
7)	M Sta	ate	30. Name and address of person who completed a Tolm C. ARKATS. 31. Date filed (Month, Day, Year) 32.	use of death frem 23a) (Type,	Print) 223 1type Street	CHest	sitoun We	d 21620

			1 - For State Registrar	State o	f Marylar		artmer <i>rtificat</i>				•	giene Reg. No.	20	06	No. of the last of	68
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W.	/Medic	al	4a. Facility Name (If not institution, giv		mber)		4b. City,	Town, or	Location of	of Death	Mary	40.0	County of	Death	61334	7 M
	Cxamiii	EI	University of Maryla			cutiv	-	ltiv	love				,			
. BX.	Funeral			Sex I□M 2【XTF	7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under Hours		8. Date of Bir (Month, Da April 3	th ay, Year)		Coun		eign
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	within 72 hours after deeth with the Maryland ene. Than "returel", or tlems 23a or 28a-f show he Medical Examinar must be notitled at	5	10a. State 10b. County	_		ity, Town or Lo								1	0d. Inside City Lim 1 ☐ Yes 2)()	
	the M	Director	Maryland Prince 10e. Street and Number	George'	s Gl	enn Da	.1e 10f. Zip	Code				10g. Citiz	en of Wh	at Coun		
	h with		12004 Green Con	ırt				0769				U.S			.,	
	tems tems	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Dece If Yes, spe	dent of His	spanic Ori	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.))- 1	4. Race - Black,	Americ White,		
36	irs afte	by Fi	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Gir Year or D	/0		1 🗆 Yes	2 X No	Specify:				Specify:	Whi	te	
Maryland 21215-0036	72 hou	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Dece	dent's Usu	al Occupa	ition	t of working	na	16b. Kin	d of Busi	ness/Inc	ustry	
121	within	Completed	Elementary/Secondary (0-12)	College (I-4or 5+)	life.	DO NOT u	se retired)	1		<i>'</i> 9					
Q 5	filed in Hygie other ent,	Be Co	12 17. Father's Name (First, Middle, Last)		Homer	naker		18. Mothe	r's Name	(First, Middle,		Home (Surname			
ylan	ould be Menta arked aric sv	To B	Ernest Rambo						Net	tie N	Mae Sco	tt				
Mar	12 sho h and 7 is m		19a. Informant's Name/Relationship (l Route Numbe					
آو _	Healt Healt tsm 2		Robert L. Brown 20a. Method of Disposition	ı - Hust		12004 Place of Dispo cemetery, crei	+ Gre	en Co	ourt.	Gler	nn Dale		rylai ation - C			
E E	Pages nent of int: if i		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		JIAIU	cemetery, crei ropolit				5/17/	2006	Alex	kandı	ia,	Virginia	a
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Beginner and the maryla marked other than "natural; or tems 23a or 28a-f show any injury or other traumatic svent, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	nesso /	,						sch's F					
	<u></u>	Н	23a. Part . Enter the disease, or com	Vjay	aused the dea						, Hyat		lle,	MD	20781 Approximate	
silvy Sept	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.					cardiac	i respiratory ai	11631,			Interval Between Onset and Death	
\mathcal{X}_{-}	/Medical		disease or condition resulting in death)	or	Or as a consec	quence of):	ser te	W 7 10	ч							
	Examiner	<u>.</u>	Sequentially list conditions,	b. Pulv	ONLUY	FI	overi	5								
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o,	ate be executed hysicien and the burial-transit	Еха	that initiated events resulting in death) Last	Due to	or as a consec	quence of):		00	(4)(
		dical	•	a Cour	estive	Hea	u t	tai	1000							
Box 6	# Ove	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out					-			2:	3d. Date	of deliver	v	
Ď.	that the death cer ed by the attendir detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nirth 2 ☐ Feta ant at time of c		Ectopic pi Other (sp						Month		Day Year	
P.O.	hat the d by the fetach	Phy	9 ☐ Unknown Part II. Other significant conditions			culting in the u	ndodvina		n in Bart I		220 Did to	obago uo	o contrib	uto to th	cause of death?	
Division of Vital Records,	S	d by	Atrial Fibrillati	7	3veast	Can	, ,		west		18	/			bly 4 Unkno	
000	aw require s been sig 2 should t	plete	Hypitet custour	Caro	rid A	utiuy	F	eno?			24a. Was		24b. We	ire autop	sy findings availal	ble
Ä	The l	Com										osy rmed? 2 No	dea	ath?	pletion of cause o 2□ No	of
Vita	Physician: this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	/			Othe			Check only o					
o	g Phys er this eral di	n; To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	28b. Time of		28c. Injury	at		ne 5 ☐ Resid)	
sion	Attending ir death. actor: After by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	th, Day Year)	Injury	М	Work 1 □ Y	es 2 🗆	No						
<u>X</u>	l or Att efter de Direct	Certification;	3 Suicide 6 Could not be determined	286. Place	of Injury - At h ng, etc. (Speci	iome, farm, str fy)	eet, factor	y, office		2	8f. Location (S City or Tox	Street and vn. State)	Number	or Rural	Route Number,	
_	Hospital 24 hours e Funeral I		29a. Certifier 1 Certifying Pt	ysician: To the	best of my kno	owledge, deatl	h occurred	at the time	e, date and	d place, a	nd due to the	cause(s) a	ind mann	er as sta	ted.	_
	To the Hospital or Attending Physician: The la within 24 burus eliter death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	edical	(Chack only 2 Medical Exal	timer: On the b	asis of examina ner stated.	ation and/or in	vestigation	, in my op	inion, deat	h occurre	d at the time,	date and p	olace, and	d due to	the cause(s)	
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			For State Registrar	ricusc			nd / Depa	artme		lealth and Death		ntal Hyg		200	5 1	705
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	/Medic Examir		4a. Facility Name (II		ve street and nu	mber)		4b. Ci	ty, Town, or	Location of De		nay 11	1	ounty of De		1
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		4	For State Registrar	1 104	St	ate of	Marylan	•	artmen			and M	lental Hy	giene	006	17070	
		20	Decedent's Name	(First, Middle	e, Last)								2. Date of De.	ath	.,	3. Time of Death	
	Physici		Donald	Lee	Brown								May	Day 12	2006	11:00 A M	
	/Medic		4a. Facility Name (If r	not institution	n, give street	and numi	ber)		4b. City,	Town, or	Location of	of Death		4c. Co	ounty of Death		
- W. W.		<u>3</u> .	Casey	House					Ro	ckv:	ille			M	ontgom	ery	
	Funeral	- 1	5. Social Security Nur		6. Sex		. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birth	place (State or Foreign intry)	
140	Director	ı	546-46-918		1 🔀 M	2 F	69	Yrs.					May 11		C		
	DG *		Usual Residence of D	Decedent 10b. County		<u> </u>	10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits	
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Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		21. Signature of Fun	1	Stown ?				2. Name an Deer I				DeVol F aithers			, 10 East 877	
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	roth Vithir Coth	Me	29b. Signature and	title of certifi	er				29	c. Licens	e number				signed (Month		
	C11			K~			m	>		D35	635			May	13, 200	06	
	>+1		30. Name and addre	ess of person	n who comple	eted cause	e of death (Ite	m 23a) (Type	, Print)	_		4.5	44	0005	0		
			Joseph K	Kaplan	, M.D.	, 60	01 Muno	caster	Mill	Roa	d, Ro	ckvi	lle, MD	2085	U		
	St	ate	31. Date filed (Monti	h, Day, Year	0 0000	32. FR	bgistrar's Sign	ature	Last.	r							
	Regist	rar	N.	NAY I	6 2008		egistrar's Sign	15 19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day May 2006 2:00P. M 13, **Physician** Blatt Celia /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lorien Nursing and Rehabilitation Center Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 8, 1910 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** 1 ☐ M 2 💢 F 184-36-8840 95 Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or iteme 23a or 28a-f show may injury or other traumatic event, the Mudical Examinat must be rediffed at once. Columbia 1 ☐ Yes 2 ☐ No Maryland Howard Directo 10e. Street and Number 6334 Cedar Lane 10g. Citizen of What Country? 10f. Zip Code 21045 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes. Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Specify Completed by Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (9-12) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wiener Max Rachel Cooperman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6964 Sunfleck Row Columbia, Maryland 21045 Etarae Weinstein -daughter 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Warwick cirownship. Beth El Cemetery 5/18/2006 Lancaster, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Senile Dementia Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown been sig 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete has to autopsy ormeot? 2 (XNo After this certificete funeral director, pag 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Mapper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funerei Dire 29a. Certifier 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fund (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier & Glanne D30641 May 15, 2006 30 Name and address of person, who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi, M.D. 3000 North Ridge Road Ellicott City, Maryland 21043

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 16

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32 Registrar's Signature

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		1 - State Registrar	ŕ		rtificate of D			eg. No.	00 11016			
Physici		1. Decedent's Name (First, Middle, Last, MR LARE		Eアア			2. Date of Dea Month	th Day	Year			
/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death		4c. County				
		Harmony Hall			Columbia			Howar	d			
Funeral Director		5. Social Security Number 6. Sec. 1577-24-9928 Usual Residence of Decedent	7M 200 F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 14,	Year)	 Birthplace (State or Foreign Country) Washington, D.C 			
Sa-f show	ctor	10a. State 10b. County Maryland Howard		ty, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
ust be no	ral Directo	10e. Street and Number 6336 Cedar Lane #2			10f. Zip Code 21044			0g. Citizen of W USA	/hat Country?			
Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show any fujury or other traumatic event, the Musical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 XNo	spanic Origin? (Sp , Mexican, Puerto Specify:	Black	14. Race - American Indian, Black, White, etc. Specify: White				
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Departr Imports any Inji		21. Signature of Funeral Service License	141		Name and Address Oing Home everly L.				. Box 784 ville, MD 21029			
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n signed b uld be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
n. After this cerdificate has been si funeral director, pege 2 should I	Completed	Chronic Pain					24a. Was ar autopsy pertorm 1 Yes 2	24b. W	ere autopsy findings available for to completion of cause of eath?			
ertifica ctor. I	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h Check only one		_ 193			
this c	မှ	1 ☐ Yes 2 No		ER/Outpatien		4 Nuising Ho		nce 6 ⊟Other				
er death. ector: After t by the funera	tification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	at es 2 □ No	28d. Describe ho	w injury occurre	d			
er de recte by ti	iii	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, stre	eet, factory, office		28f. Location (Str. City or Town	eet and Number	r or Aural Route Number,			

To the Hospital or Attending Physician: The law requires their the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certificati

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

MD

29c. License number 0 30 5 7 3

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

5-15-06

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print)
FORD ND, 11065 Littly Patoxint Parkwal Columbia ND 21044. MINFORD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

MAY 1 7 2006



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Zabetr rana 2006 5:50 PM Ma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death County Columbia

If Under 1 Year | If Under 24 Hrs. Tenera Howard toward 5. Social Security Number 6. Sex 7. Age (În yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 26, 1919 Birthplace (State or Foreign Country)
Georgia **Funeral** 1□M 24 F Days Hours 253-24-9728 86 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2\No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3004 N. Ridge Rd. Ітетне 23а #H-302 21043 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Samuel Byrd Ledbetter Emma Napier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 3222 Hearthstone Road Ellicott City, MD 21042 Joyce B. Raine/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of the Important: If its any Injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/17/06 Beltsville, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** respirator /Medical Examiner Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physicien and is the burial-transit Exam resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical SS anding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 4☐Pregnant at time of death Year signed by the a d be detached fo 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t irector, page 2 s 24a. Was an autopsy of Vital 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funaral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident Injury 5 Pending investigation · 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ec ne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ee 32. Rigistrar's Signature MAY 1 7 2006 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

park

			1 - For State Registrar	State of Ma	aryland / Dep		Health and		iene	17074
			Decedent's Name (First, Middle, Last	it)			D Guill	2. Date of Dea	eg. Nov. UUD	3. Time of Death
п	Physici		Robert Cooper					Month	Day Yea	r M
	/Medi		4a. Facility Name (If not institution, give			4h City Town	, or Location of De	May 13	4c. County of De	11:45p
	Examir	ier	Laurelwood Car					eau i		
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday)	Elkto		rs. 8 Date of Birth	Cecil	
	Funeral Director			MXM 2□F	81 Yrs.	Months Day:		in. (Month, Day	Year)	irthplace (State or Foreign Country)
			Usual Residence of Decedent					APLII	6,1925	NY
	ylan		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ma	Ş	MD Cecil		Perry	ville				1 ☐ Yes 2 🙀 No
	n the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?
	h wil	a D	5248 Pulaski	Hwv.		2190	13		U.S.A.	
	dea	Funeral	11. Marital Status	12. Was Decedent Amed Forces?		Was Decedent of	Hispanic Origin?	(Specify Yes or No-	14. Race - An	
9	ours after death with the Marylan ral', or Itams 23a or 28a-f show Evs citrer inset be ricitled at		1 Never Married 2 Married	1 ☐ Yes 24☐ N	No		ban, Mexican, Pu	ento Hican, etc.)	Black, Wh	
21215-0036	hours after death with the Maryland tural', or Itams 23a or 28a-1 show II Evanither must be notified at	d by	3 □Vidowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 ☐ No	o Specify:		Specify: E	Black
5	72 nai	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occu	upation e during most of v	vorkina	16b. Kind of Busines	s/Industry
2	within ene. than	ldr	Elementary/Secondary (0-12)	College (1-4or 5)+) (e during most of v red)	9		
	filed w Hygier thar ti		12	-	Wine	dow Was	her		Constr	uction
<u>n</u>	ld be filec ental Hyg ked othal ic avant,	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lam <i>e (First, Middl</i> e, M	Maiden Sumame)	
<u>₹</u>	should nd Men marke imaric	2	Aron Cooper				Olivi			
Maryland	C1 00 00 00		19a. Informant's Name/Relationship (7			ng Address (Stree	et and Number or	Rural Route Number,	City or Town, State,	Zip Code)
-	s 1 and f Health item 27 othar tr		Phyllis Wellin	gton/Nie		Color	a Rd.,	Colora,	MD 219	17
0	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State		natory or other pla			20c. Location - City o	
<u>E</u> .	men men ant:		'4 ☐ Donation 5 ☐ Other (Specify)	R.A. Fe	erris I	nc. May	y 15,200	6 West	Chester, PA
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	500		. Name and Addr	ess of Facility			
ш_	<u> </u>		A THE			250 F	Hained	Funera:	T Home	01001
			23a. Part1. Enter the disease, or some shock, or heart failure. List only of	lications that caused one cause on each lir	the death. Do not ent	er the mode of dy	ring, such as card	iac of respiratory arre	est, MD	2 1 2 1 ate Interval Between
	Pnysician	ë n	Immediate Cause (Final disease or condition	T	There -	7. 7	011=			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	0 /19	2			wiit
	Examiner		Securetially liet annelitions	En	O STALE-	Zsuron	ic /	merza		Unk
den.	п ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of).		po to	/	1	
	nd nd trans	Examiner	that initiated events	c. /2	ESVNO	m	21200	ac INTE	rehun	Unk
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due (o (or as a	a consequence of):	1		,		
8760,	ate b hysic he bi	Ical		d						
9	nd ph ng ph a as th	Physician/Med	IF FEMALE:							
Вох	death certific e attending p id for use as i	an/l	23b. Was decedent pregnant	23c. If yes, outcome of 1 □ Live birth		Ectopic pregnanc	cv		23d. Date of de	
	0 0 0	sici	in the past 12 months?	4☐Prøgnant at 9☐ Unknown	time of death 5	Other (specify)	,		Month	Day Year
P.O.	that the de led by the a detached	Phy	9 🗆 Unknown							
	pe o	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the ur	nd <i>e</i> rlying cause gi	iven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
D.C	v requir been si should	Completed						1 🗆 Ye	s 2□No 3□P	robably 4 Unknown
Vital Records,	has be	ple						24a. Was an autopsy		utopsy findings available
<u>~</u>		Son						perform		completion of cause of
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of D	eath Check only one		92110
	Physician: r this certific ral director,	2	1 ☐ Yes 2 ☐ M6	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	t 3□ DOA Ot	her: ursing	Home 5 ☐ Resider	nce 6 Other (Spe	ecify)
n of	ding PI h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	23a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Inju		28d. Describe how		,
.0	Attending in death. actor: After by the fune.	atio	2 ☐ Accident investigation	1			Yes 2 No			
Division	I or Attendate death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could nyt be 4 ☐ Homicide determined	a e. Place of Inju	ry - At home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
	Ital or rs afte ral Dir	Cer		1					214(0)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Phy	sician: To the best of	of my knowledge, death examination and/or inv	occurred at the ti	ime, date and place	ce, and due to the car	use(s) and manner as	s stated.
	tha H in 24 tha F tha F	ledi	one)	and manner sta	ted.	ostigation, in my	opinion, death oct	cured at the time, da	e and place, and due	o the cause(s)
	To To	Σ	29b. Signature and title of centier			29c. Licens			d. Date signed (Mont	
1			111/			D59	10/3		15 MAY O	06
	Z		30. Name and address of person who c	ompleted cause of de		Print)				
			Arker 1 Steer		817	Citurci	LUAM	UZZ HE	WLASTLE	0E 19720
	Sta	-	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					
	Registr	ar	MAY 1 7 2006	Shewed D	gover					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FLORENCE G. CLARK MAY 2006 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1854 HARBOR DRIVE CHESTER QUEEN ANNE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 K F Yrs Director 212-20-7705 80 JUL. 21. MD Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 1854 HARBOR DRIVE 21619 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7. Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, The ODGE. FACTORY WORKER 11 MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ STANLEY GODLEWSKI VIOLA DOMINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES D. CLARK / HUSBAND 1854 HARBOR DRIVE, CHESTER, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other plan
MARYLAND VETERANS
CEMETERY 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/08/2006 HURLOCK, MD 21. Sign to the of June al Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Pent 1. Enter the disease, of complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Small Cell CRAUN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 □ No 3 □ Probably 4 □Unknown Completed 24a. Was an autopsy performed 1 Yes 2 2 1 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 54 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA s after death.

I Diractor: After this of in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Within 24 hours are your to the Funeral Dir 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

TAMIE

TIAKMS 31. Date filed (Month, Day, Year) POINT

32. Registres Signature

Cons

2006

STEVENSVILLE

		For State Registrar	State	of M	aryland / Dep <i>Ce</i>	artment of I rtificate of		d Mental Hy	/giene	006	17076		
Physic	ian	1. Decedent's Name (First, A						2. Date of D	eath Day	Year	3. Time of Death		
/Medi			ROBERT	CIGA				MAY	10	2006	11:19 P ^M		
Exami	ner	4a. Facility Name (If not instit		number)		4b. City, Town, o		eath	4c. County of Death				
		73 CLIPPER 5. Social Security Number	6. Sex	7 Ac	je (In yrs. last birthday	CHESTI If Under 1 Year	If Under 24 F	Irs. 8. Date of B		ENT			
Funeral Director		138-05-0684	1 M 2□			Months Days		in. (Month, D	8. Date of Birth (Month, Day, Year) SEPT • 16 • 1917 9. Birthplace (State or Fore Country) NY				
ō		Usual Residence of Deceder	t					DEFI.	10,191	-/	14.1		
anylar show	_	10a. State 10b. Co			10c. City, Town or L						10d. Inside City Limits		
Ba-f	Director		ENT		CHESTERT						1X Yes 2 □ No		
with ti		10e. Street and Number 73 CLIPPER	WAY			10f. Zip Code			10g. Citize	en of What Cou	ntry?		
1215-0036 within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Madical Everth et rivet be rollined at	Funerai	11. Marital Status)ecedent	Ever in U.S. 13.	Was Decedent of H		/Crosity Vos or N	- 14	USA . Race - Ameri	ann Indian		
r Iten	F	1 Never Married 2 ▼	Armed	Forces?		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	0- 14	Black, White,			
ours a	by	3 ☐ Widowed 4 ☐ Divo	rced If Yes, Year	Give or Dates:		1 ☐ Yes 2 🛣 No	Specify:		S	pecify: WI	HITE		
72 hours	Completed	15. Dece (Specify only hi	dent's Education ghest grade complete	ed)	16a. Dece	dent's Usual Occup	pation during most of v	vorkina	16b. Kind	of Business/In	idustry		
Mithin Methin	I du	Elementary/Secondary (0-		e (1-4or 5	D+)	kind of work done DO NOT use retire		·g					
N 5 5 5	ပိ	17. Father's Name (First, Mid	dle l ast)	1	PLA	NT MANAGE		lame (First, Middle			ODUCTION		
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. If Is marked other than "naturel", or Items 23a or 28a-f show treumetic event, Ite Medical Evertil activust be notified at	To Be		SANEK				FRANC			umame)			
laryian 2 should be and Mental 18 marked of 19 munitic ev	۳	19a. Informant's Name/Relat			19b. Maili	ng Address (Street				Town. State. Zir	c Code)		
		OLGA L. CIGA	NEK/ WIFE			CLIPPER W					, , , , , , , , , , , , , , , , , , , ,		
		20a. Method of Disposition			20b. Place of Dispo	osition (Name of matory or other plan	ce)	Date	20c. Loca	tion - City or To	own, State		
Pages Pages nent of ant: If it		1 ☐ Burial 2 😿 Cremat '4 ☐ Donation 5 ☐ Other		om State	CHESAPEAI	KE CREMAT		-11-2006	STEV	ENSVILI	E, MD		
		21. Signal to 1 Fun	io Livensee	1	2	LC 2. Name and Addre	ss of Facility	TN S MELI	JAM 12T	DATED AT T	HOME, P.A.		
o 825 8	0 0	1.Kiy	telfene	ren		30 SPEER	ROAD, C	HESTERTO	NN, MI	21620	IUPIE, P.A.		
		23a. Part1. Enter the disease shock, or heart failure.	e, or complications the List one cause of	at caused in each lii	i the death. Do not en ne.	er the mode of dyir	g, such as card	iac or respiratory a	rrest,		Approximate Interval Between		
Prysician		Immediate Cause (Final disease or condition resulting in death)	_ a. N	MG	HODGES	KIN'S	LYMY	HomA			Onset and Death ZBYRS		
/Medical Examiner		roduling in death)	Due	to (or as	a consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate	b. — Due	to (or as	a consequence of):								
uted	Examiner	Cause (Disease or injury that initiated events	1										
U, exectantantantantantantantantantantantantant	Exa	resulting in death) Last	Due	to (or as	a consequence of):								
68 / 60, cate be executed physician and the burial-transit	dicai		d										
		IF FEMALE:	1										
box to death certiff death certiff e attending of for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 □ Liv	e birth	of pregnancy 2 Fetal death 3	Ectopic pregnancy	,		230	d. Date of delive	*		
he de the check the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at iknown	time of death 5	Other (specify)				MOTO	Day Year		
hat t	Ph	Part II. Other significant con	ditions contributing to	o death bi	ut not resulting in the u	nderfying cause giv	en in Part I	23e. Did t	obacco use	contribute to th	ne cause of death?		
dS, uires t signe id be d	d by		· ·		3	, , , , ,				No 3 □ Prob	_		
ecord law requir as been si 2 should l	lete							24a. Was	20 2	Ab Word auto	nov findings available		
* • - 3	ompleted							autoj perfo	osy irmed?	death?	psy findings available mpletion of cause of		
VICAL P sicien: Th certificate rector, pag	O	25. Was case referred to med	dical				26 Place of D	1 ☐ Yes	2 No	1 🗆 Yes	2□ No		
- A 0	ToB	examiner? 1 ☐ Yes 2 \$ No	Hospital:	☐ Inpatie	nt 2□ER/Outpatier	t 3 DOA Oth		Home 5 Resi		Other (Specifi	v)		
0		27. Manner of Death 1 Natural 5 Per		te of Injur	y 28b. Time of Injury	28c. Injun Worl	/ at	28d. Describe			<i>'</i>		
r Attending I er death. rector: After by the funer	catic	2 Accident inv	estigation				Yes 2 □ No						
_ n = = -	ertification;		uld not be ermined 28e. Pla bu	ace of Injuiced in the contract of the contrac	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (3 City or Tox	Street and N vn. State)	lumber or Rura	l Route Number,		
pitel or Atten ours after deat nerel Director: filled in by the	O	COn Contillor 4 Conti	frie Bhalaise T								<u> </u>		
ely Fur	edical	29a. Certifier 1 Certi (Check only 2 Medi	cal Examiner: On the	the best of abasis of anner sta	of my knowledge, death examination and/or in- ited	occurred at the ting restigation, in my op	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s) an date and pla	d manner as stace, and due to	ated. the cause(s)		
To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of cer				29c. License	number		29d. Date s	igned (Month, L	Day, Year)		
77		1 Zuil	F. Cia	m	et MI) 73	504	8	51		06		
(3)		30. Name and address of pers			eath (Item 23a) (Type,	Print))		01				
gratisms		ERIC F. CIG		, 25	40 CENTREV	ILLE ROAL	, CENTR	EVILLE,	MD 216	517			
Sta	-	31. Date filed (Month, Day, Ye	0000		ar' Signature	1. 11	0						
Registi	ar	5.6	AV 1 2 2008		Matriage La	A Share							

			1 - For State Registrer	State of Marylar		ertificate of				* I may my my
	Physic	ian	1. Decedent's Name (First, Middle, Las Florence Lilliar					2. Date of Death	Day 06 Year	3. Time of Death
,	/Medi Examir	cal	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	May 10,	4c. County of De	03:40 а м
			Chestertown Nursi 5. Social Security Number 6. S.				town	T	Kent	
В	Funeral Director	9			98 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, December	9,1907 9. Bi	rthplace (State or Foreign Country) CT
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L					10d. Inside City Limits
	he Mar 28e-f et otified	Director	MD Kent		Chest	ertown				1⊠Yes 2□No
	h with t	al Dir	10e. Street and Number 101 Morgnec Road	, G101		10f. Zip Code 21	.620		g. Citizen of What C ISA	Country?
036	filed within 72 hours after death with the Maryland Hygiene. other then "neturel", or items 23a or 28e-f ehow ent, the Weddon Evant at roust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
0-61	n 72 ho "netur edicel	leted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business	s/Industry
212	illed within I Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem		<i>D)</i>	1	wn Home	
Maryland 21215-0036	d la la	To Be (17. Father's Name (First, Middle, Last) Edward Parkhurst				18. Mother's Name Lue 11	<i>(First, Middle, M</i> .a Kent	aiden Sumame)	
	12 sh h and rie m		19a. Informant's Name/Relationship (7 Eleanor Crooks/da						City or Town, State,	
Baitimore,	Pages 1 and ment of Healtl ent: If item 27 ury or other t		20a. Method of Disposition 1 □ Rurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State	emetery, cre	osition (Name of Imatory or other place d Cemeter	(e)		orwich, C	
Ball	permit. Pages Department of I Importent: If it eny injury or o		21. Signature of Funeral Service Licen	efela	2	2. Name and Address Fellows, 130 Spee	ss of Facility Helfenbe	in and N	ewnam Fun	eral Home, P.
	Pirysician /Medical Examiner	01 1	23a. Part 1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Meations that caused the death one taups of each line. a	ina	ter the mode of dyin	g, such as cardiac c	or respiratory arres	wii, rii 21	Approximate Interval Between Onse and Death
_^	rcate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, fary, leading to influed acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence						1
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DOX	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
cords, r	en signed by	by	Part II. Dther significant conditions co	ntributing to death but not resu	Iting in the u	inderlying cause give	en in Part I.		cco use contribute to	o the cause of death?
	sicien: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed						24a. Was an autopsy performe	death?	utopsy findings available completion of cause of
or vital	hysicier this certif al directo	To Be	1 163 2100	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier		Nursing Hon		ce 6 □Other (Spe	cify)
	nding P tth. : After t e funera	tlon:	27. Manner of Teath 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	at 2 (? (es 2 □ No	8d. Describe how	injury occurred	
UNIS S	l or Atter after dea Director I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office	2	8f. Location (Stree City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exemi	sician: To the best of my knowner: On the basis of examinate and manner stated.	vledge, deat on and/or in	h occurred at the tim vestigation, in my op	e, date and place, a sinion, death occurre	and due to the caused at the time, date	se(s) and manner as	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Mont)	n. Day, Year)
1	1)		30. ame and address of person who co	om eted cause of death (em	M. (T 23a) (Type,	Print 1	648	8 3	5-11-0	06
	m5		31. Date file (Month, Day, Year)	1 amin M 32. Registra Signat	LP.	Ches	rterto	wn, n	MX 216	20
•	Sta Registr		MAY 1 2	2006		And				

		1 - State of Maryland / Department State of Maryland / Department Certification	ent of Health and Mate of Death	lental Hygier	ZUUb	17078
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	Nancy Patricia Crawford 4a. Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location of Death	00 /	5 2000 4c. County of Deat	D 1.30 MM
- Cxalling	C.	Doctors Hospital	Lanham			George's
Funeral Director		1 M 2 X F Yrs Mont	nder 1 Year If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, Yea	ur) 9. Birt Co	hplace (State or Foreign untry)
AF -		5/8-/0-8084 54 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location		Nov. 30,	1951 Wa	sh., DC
d 21215-0036 d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-1 show int, the Medical Exercitors must be notified at	Director	Maryland Prince George's	University	7 Park		10d. Inside City Limits
MM Can Can Can Can Can Can Can Can Can Can	Dire	10e. Street and Number 7004 Forest Hill Drive	Zip Code 20782	10g. (Citizen of What Co	•
Geath death	Funeral		ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No-	United 14. Race - Ame	rican Indian,
36 rs after	by Fu	1 Never Married 2 Marned 1 Yes 2 No	s 211 No Specify:	nican, etc.)	Specify:	frican
15-0036 172 hours after death w ratural; or items 23a	ted k	15. Decedent's Education 16a. Decedent's U	Jsual Occupation	16b.	Kind of Business/	merican ndustry
1218 vithin 7 ans. "r than "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of life. DO NO	f work done during most of workii T use retired)	ng		,
d 2.		7 Benefit 17. Father's Name (First, Middle, Last)	Claim Speciali	St (First, Middle, Maide	Priva	te
aryland 2 should be filed and Mental Hygi marked other umatic event, 1	To Be	Herbert J. Scott, Sr.		Ida Mae	,	
ash and a			ress (Street and Number or Rura			
5 8 2 5		20a. Method of Disposition 20b. Place of Disposition (/	orest Hill Dr.,		ty Park,	
		r⊟Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln	or other place) Cemetery 5/22/		Brentwo	
Baltimo permit. Page Department of Important: if Important: if eny injury or		21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility	stewart Fu	neral Ho	ne
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Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.	ic breast		cer	Approximate Interval Between Onset and Death
Examiner		Due to (or as a consequence of):				8 month
P =	luer	Focuse (Disease or injury Due to (or as a consequence of): Cause. (Disease or injury				D IV WING
8760, rate be executed thysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
	dical E	d.				
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Box 6	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic	c pregnancy		23d. Date of deliv	ery Day Year
P.O. that the dad by the detached	hysic	1 ☐ Yes 2 █ No 4 ☐ Pregnant at time of death 5 ☐ Other 9 ☐ Unknown 9 ☐ Unknown	(ѕреспу)			,
Division of Vital Records, P.O. Box 6 to attending Physician: The law requires that the death certific after death. Director: After this certificate has been signed by the attending for in by the tuneral director, page 2 should be detached for use as	l by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.			the cause of death?
cord w requir been si should	Completed			1 ☐ Yes 2		bably 4 Dunknown
I Rec The tav	mo.			autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital F sician: Th certificate	Be	25. Was case referred to medical examiner?	26. Place of Death	1	0 10 705	ZUNO
Sion of Vita tending Physician: leath. tor: Atter this certific the tuneral director,	. To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Hopatient 2 ☐ ER/Outpatient 3 ☐ I 27. Manner of Death		e 5 Residence		fy)
sion ending lasth. or: After he funer	atio	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	28c. Injury at Work? 1 Yes 2 No		.,, 00001100	
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ita lec		29a. Certifier 1 Contribing Physician: To the best of my knowledge, death occurre	ed at the time, date and place, a	nd due to the cause(s	s) and manner as s	tated
the He hin 24 the Fe Fe mpletel	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation	ion, in my opinion, death occurred	d at the time, date an	d place, and due t	the cause(s)
To To con		29b. Sighature and title of certifier Avand M.D.	29c. License number	29d. Da	ite signed (Month,	Day, Year)
1 (5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11-110	1-19	1,16,	2006
4		Sgreev Anand, 7343-A Hau	nover Parla	way Gre	enbelt, 1	Mary land
Stat Registra		MAY 1 8 2006 Registrar's Signature	29c. License number D-3348 nover Parlu		,	20770

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Keeyon Domtic Crest

Please Type or Print in Black Indelible Ink

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State of Maryland /	Department of Health and Mental Hygie	n

Reeyon Donnic C	1 	- For State egistrar	e of Maryland / i	•	cate of Deatl			Reg No.	200	6 1707
Physicia Medical Examir	174	Decedent's Name (First, Middle,	_ast)				2. Date of I Month May 13	Day	Year	3. Time of Death 0653 hrs
VIEUICAI EXAIIIII	_	KEEYON CREST 4a. Facility Name (if not institution,	give street and number)		4b. City, T	own, or Location of			County of Deat	
- d		Prince George's Hospit			Cheve	erly		Pr	rince Georg	e's
Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs. last bi	rthday) If Unde		Min.	,	Fore	
Director		1.01.12	<u> </u>		Yrs. 2	8	03/0	5/200	6 W	ASHINGTON, DO
any		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Tow	n or Location					10d. Inside City Limits
*	5	DC	_	WASHI	NGTON					1 X Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number			10f. Zip				en of What Cou	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		4527 EADS PLAG	I 12. Was Decedent Ev			20019	gin? (Specify Yes or		NITED S	TATES
leath w	Funeral	1 X Never Married 2 Mar	ied Armed Forces?	No			, Puerto Rican, etc.)		White, etc.	
after d	Þ.		ced If Yes, Give Year or Dates:			X No specify:			Specify: BL.	
hours "natur		15. Decedent's Education (Specific Elementary/Secondary (0-12)	y only highest grade compl College (1-4 or 5+		Decedent's Usual during most of wor			16b. Ki	ind of Business	Industry
215-0036 be filed within 72 h ntal Hygiene. rked other than "r ent, the Medical E	Completed	0			NONE			NO	NE	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, L			_		's Name (First, Midd		Surname)	
2121 nuld be fi marked c event,	To Be	WILLIE J. TURN 19a. Informant's Name/Relationshi		1	9b. Mailing Address		LIS L. CR		y or Town, State	e, Zip Code)
and 2 shou cealth and N	-	IVELIS L. CRES	ST / MOTHER		4527 EADS		WASHINGTO	N, DC	20019	
ore, ML es 1 and 2 s of Health a If item 27		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State		e of Disposition (Namatory or other place)		Date	20c. L	ocation - City or	Town, State
Baltimore, permit. Pages I an Department of He Important: If ite	1	4 Donation 5 Other Spe	cify:	1	NGTON NAT		05/24/06		SUITLAN	
Baltimo permit. Page Department of Important: injury or oth		21 Signature of Funeral Service L	censee 0		22.MARSH	Address of Facility	NERAL HOM ROAD SUI	E OF 1	MARYLAN	D, INC.
Physician	1	23a. Part I. Enter the disease, or c	omplications that caused th	e death. Do	not enter the mode	of dying, such as o	cardiac or respiratory	arrest, sho	ck, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	falure. List only one cause of Immediate Cause (Final disease	a. Sudden unex	plained	death in in	nfancy				Death
		or condition resulting in death)	Due to (or as a conseq	uence of):						
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):						
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60, rate be executed physician and re burial - transi	Medical	X UNPENDED	AMENDED ite		7,28a-f,perN	E ,g858,8/2	2/06 TT	1 224	, Date of deliver	
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Box 687 e death certific the attending p	Physician	1 Yes 2 No 9 Unkr	own 9 Unknown	me of death	5 Other (Spe	ecify)				
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of Vi Physi ter this eral diu	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Yea	hanned.		28c. Injury at World			ry occurred	er.
On C ending sath. or: Af	tion	1 Natural 5 Pendi	ng Fnd 5/13/		od Oo am	1 Yes 2 X	No unk			
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Dispital hours and meral		4 Homicide determined Ph		ound at			Washin	gton. D).C.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only Cel tillying Fit	ysician: To the best of my niner:On the basis of exam	knowledge, of ination and/o	death occurred at the or investigation, in m	e time, date and pi ly opinion, death o	ccurred at the time,	date and pla	d manner as sta ce, and due to t	nted. he cause(s)
To wit	Med	29b. Signature and title of certifier	and manner stated.		29	ic. License number		29d. [Date signed (M	onth, Day, Year)
		Patri aim	· - Hollate	10		O.C.M.E.		May	14, 2006	
Sec		30. Name and address of person				Penn Street R	altimore, MD 21	201		
	tate	Patricia Aronica-Pollak 31. Date filed (Month, Day, Year)	32. Registrar		11111GI (111F		animore, MD 2	-01		··
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			1 - For State Registrar	State of M	laryland / Dep	oartment e <i>rtificate</i>			nd Mer		ene	105	1	7001
	Physici /Medio		1. Decedent's Name (First, Middle, Last Robert D. Car	_						Date of Death Month		Year 6		of Death P. M
)	Examir		4a. Facility Name (If not institution, give 8101 Connecticut 5. Social Security Number 6. Se	Avenue #			vy C	ocation of	Death	Date of Birth	4c. County Mont	of Death		e or Foreign
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	he Marylar Ba-f show	Director	Maryland Montgome:	ry	10c. City, Town or Chevy (Chase							1 🔼 Y	City Limits es 2 ☐ No
	a 23a or 2 rual be n	ral Dir	8101 Connecticut				0881				g. Citizen of V United	Sta	tes	
9036	within 72 hours after death with the Maryland ene. than *neturel', or items 23e or 28e-f ahow fra Medical Exemirer must be rotified at	d by Funeral	11. Marital Status 1 □ Never Married 21 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 M Yes 2 ☐ If Yes, Give W Year or Dates.	? No	. Was Decede If Yes, specif 1 ☐ Yes 2	fy Cuban,	oanic Origi Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- n, etc.)	Bfac	e - Ameri k, White, . Whi		
Maryland 21215-0036	d within 72 h piene. ir than *natu ine Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or	5+) (Giv	edent's Usuaf re kind of work DO NOT use 11 and	done du retired)	ring most o			S. Go			
yland	should be filed ind Mental Hygie marked other umatic avant, II	To Be C	17. Father's Name (First, Middle, Last) Carlton C. Carte					Rosa1	lie R	ichard				
altimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f ahow morticant: if item 27 is marked other than "natural", or itema 23e or 28e-f ahow my injury or other traumatic avant, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (T) Patricia A. Carte: 20a. Method of Disposition 1□ Burial 2□ Cremation 3□ F 4℃ Donation 5□ Other (Specify)	r/ Wife	20b. Place of Disp Georgeto	Conne	ctic	ut Av	renue Date	# N406	City or Town, Chevy C. Location - ashing	Cha:	se, MD	20815
Balti	Departm Departm Importa any inju		21. Signature of Funeral Service Licens		Medical	22. Name and	Address	of Facility	Colum		rtuary , D.C.			, Inc.
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lon of	Attending Phy ir death. ector: After thi by the funeral o	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da			. Injury at Work?		28d. I		injury occurre		<u>" </u>	
DIVISION	7 8 7 7	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	treet, factory, o	office		28f. L	ocation (Stree Dity or Town, S	et and Numbe State)	r or Rura	l Route Nu	mber.
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Nadical Exami	sician: To the best ner: On the basis o and manner st	of my knowledge, dea t examination and/or ii ated.	th occurred at nvestigation, in	the time, my opin	date and p ion, death	place, and d occurred at	ue to the caus the time, date	se(s) and man and place, ar	ner as st nd due to	ated. the cause	(s)
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(5	5)"	1	30. Name and address of person who co	ompleted Juse of d		Print) 45: Wa	30 Co	onnec	ticut	Ave. 1	J.W. Su	ite	104	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 16		ar's Signature	books								

	1	For State Registrar Decedent's Name (First, Middle, Last	•		ent of Health and eate of Death		Reg. No. 200	6 708
iciar dica nine	n il	Peggy Ann Davis la. Facility Name (If not institution, give		4b. 0	City, Town, or Location of Dea	Month May 1	Day Year 15, 2006 4c. County of De	9:30 a
al	5	Union Hospital o	ex 7. Age (In yrs.		Elkton nder 1 Year If Under 24 Hr ths Days Hours Mir	n. (Month, Da)		irthplece (State or Fore
	(213-36-0925 Usual Residence of Decedent 10a. State 10b. County	66	ty, Town or Location		4/10/19	940 Ma	ryland 10d. Inside City Lim
1	Lect	Maryland Cecil 10e. Street and Number			. Zip Code		10g. Citizen of What (MXYes 2 ☐ I
-	ē _	306–4 Mansion Dri Apts. 11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was D	1903 ecedent of Hispanic Origin?	Specify Yes or No-		rencan Indian,
1	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	If Yes,	specify Cuban, Mexican, Pue os 2 No Specify:	erto Rican, etc.)	Specify: Wh:	
- Intend	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) Cottege (1-4or 5+)	life. DO NO	f work done during most of w T use retired)	orking	16b. Kind of Busines	s/Industry
0	n n	17. Father's Name (First, Middle, Last) Edgar Allan Dill	2	Escort C		ame (First, Middle, e Margare		
F	0	19a. Informant's Name/Relationship (Type, Print)	-1	ress (Street and Number or F	Rural Route Numbe	r, City or Town, State,	Zip Code)
	-	Leslie John Davi 20a. Method of Disposition 1 X Burial 2 Cremation 3	20b. F	Place of Disposition cemetery, crematory	or other place)	Date	20c. Location - City of	
		* 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licenses)	· · · · · · · · · · · · · · · · · · ·		e and Address of Facility C	rouch Fur		
		23a. ert1. Enter the dill ase, or com shock, or heart failu . List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a. Due to (or as a consec	h. Do not enter the	South Main St mode of dying, such as cardi g uclive Puls	ac or respiratory an	rest.	Approximate Interval Between Onset and Death Unknow
	Examin	Securitary list on ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t		active Pula	uouary	Disacuse	Ynkno
13	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	al death 3 □Ectop	ic pregnancy r (specify)		23d. Date of d Month	elivery Day Year
3	Dy P	Part II. Other significant conditions of	contributing to death but not res	sulting in the underly	ng cause given in Part I.	23e. Did to	bacco use contribute es 2 No 3 F	to the cause of death? Probably 4 Unkno
	Completed					24a. Was a autop perfor	sy prior to med2 death?	autopsy findings availa completion of cause is 2 No
1		25. Was case referred to medical examiner?	Harmania A		The second secon	eath (Check only or	ne)	
- III	ation; Io	1 Yes 2 No 27. Manner of Death 1 €Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No		ence 6 Other (Sp ow injury occurred	ecify)
- 1221	Certifica	3 Suicide 6 Could not b		ome, farm, street, fa	ctory, office	28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
	edical	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occu ation and/or investiga	ation, in my opinion, death oc	curred at the time, o	date and place, and du	e to the cause(s)
1	<u>≅</u> -	29b. Signature and title certifier			29c, License number D00233; St Stute 7	1 2	29d. Date signed (Mor	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MAY MARY 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth KEN HESTER RIVER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🗶 F 82 11, 1923 POLAND 160-28-5153 AUG. Director Usual Residence of Decedent 10d. foside City Limits the Maryland 10a. State 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director MD QUEEN ANNE CENTREVILLE 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number ANNE QUEEN 173 SYMPHONY WAY 21617 death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 Ie marked other then "natural", or Ite 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE'S AID HEALTH CARE 10 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KTIRACKA **TSCZINSKA** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IRENE HOFFMAN/DAUGHTER 173 SYMPHONY WAY, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Importent: If ite ony injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KINGSLEY CEMETERY MAY 16,2006 CHESTER, MD 21. Signatura of uperal 89 rvice Licensee once. HELFENBEIN, & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastasis Physician archama /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probebly 4 Winknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 \ No 1 🗆 2 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only on Be 200 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After Matural 5 Pending investigation 1 Yes 2 No death. 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD am Name and address of person who completed cause of death (Item 23a) (Type, Print) me 31. Date filed (Month, Day, Year) 32. Registy State MAY 15 2006 Registrar

State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 0104 AN 10 -sabel 300G /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Ken hestertown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs, last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 XF Months Days Hours 164-26-7522 90 13/1915 PA Director 12/ Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Director MD Queen Anne's Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1219 Dudley's Corner Road 21651 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Celia Meskauskas Anthony Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Powelson/Daughter 125 Hickman Ave Gloucester City NJ 08030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Crumpton Cemetery 5/15/2006 Crumpton MD 4 ☐ Donation 5 ☐ Other (Specify) ows, Helfenbein & Newnam Funeral Home 21. Signature of Funeral Service Licensee Fellows, uk s 370 W. Cypress St. Millington MD 21,651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one class on each line. ordiac or respiratory arrest, Approxit te Interval to w Immediate Cause (Final disease or condition resulting in death) Physician man 1 /Medical Due to (or as a consequ Examiner OURLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospitel or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknows signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ nknown has been sig ge 2 should b 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death Check only examiner? npatient Hospital: 2 : After this c ၉ 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ate of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Vatural 5 Pending 1 TYes 2 No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funerai (29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year, who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ms ami 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Month Vear **Physician** Frances L. Dickerson May 8:35 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis HealthCare - The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ xF Yrs. Dec. 14,1928 Maryland 215-20-1662 Director Usual Residence of Decedent the Maryland 10d. tnside City Limits 10a. State 10c, City, Town or Location 10b. County ehow r than "natural", or items 23a or 28a-f ehov tre Medical Examiner must be notified at MD Caroline 1-Yes 2 No Federalsburg Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21632 United States 111 Smith Street Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: B1ack Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry alth and Mental Hygiene.
27 is marked other than "r Etementary/Secondary (0-12) College (1-4or 5+) Food Processing Canning Factory Worker 11 (Grad) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ella Virginia Dickerson John Henry Prattis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health item 27 i Charles Dickerson/Son 121 Davis Lane. Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: if it any injury or o ō 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 05/26/06 Federal Hill Cem. Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat artery infact left middle cerebral **Physician** weeks disease or condition resulting in death) /Medical Examiner Hypertension Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and U-transit or Attending Physician: The law requires that the death certificate be executed 4 therosclussis Due to (or as a consequence of) physicien a Division of Vital Records, P.O. Box 68760. Physician/Medical the attending p IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown carcinoma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page performed? 2 No 1 ☐ Yes 2 ☐ No this certificete 1 Yes After this certifice funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Intury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeret Director: , completely filled in by the I 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ۽ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25933 5.12.06

State Registrar 31. Date filed (Month, Day, Year) MAY 1 6 2006

MICHAEL

LE / M D 32. Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

REWLEY

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DUTCHMAN'S LANE

EASTON, MD21601

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		1 - State Registrar			Cei	rtificate	of D	eath			Reg. No.	2006	7085
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/Med Exam		4a. Facility Name (If not institution, gir		r)		4b. City, To	wn, or L	ocation o	f Death	11100	40.	2006 County ol Death	0.23
Exam	illei	Washington Coun	ty Hospita	il		Hag	erst	town				W <mark>ashing</mark>	ton
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s 1 and 2 f Health item 27		Pamela J. Grace - 20a. Method of Disposition	· Daugnter	20b. P		sition (Name matory or othe				ate		ation - City or T	own, State
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ath cer tendir	lan/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fetal	death 3	Ectopic preg					23	3d. Date of deliving Month	very Day Year
the de	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (speci	ify)						,
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Attending F er death. rector: After by the funera	atlo	1 Matural 5 Pending 2 Accident investigation	on	y rear	- Injury	М		es 2 🗆 N	No				
or Att or Att in by t	Certification:	3 Suicide 6 Could not determined		njury - At ho etc. (Specify	ome, farm, str /)	eet, factory, o	iffice		2	81. Location (S City or Tox		Number or Rui	ral Route Number.
spitei ours a neral i		29a. Certifier 1 ☐ Certifying P	hysician: To the bes	st of my kno	wledge, deat	h occurred at	the time	date and	d place, a	nd due to the	cause(s) a	and manner as	stated
DIVISION OF VITAL RECORDS, P.O. BOX OF To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Exe	miner: On the basis and manner	of examinat	tion and/or in	vestigation, in	my opir	nion, deat	h occurre	ed at the time,	date and	place, and due	to the cause(s)
To ti To ti	Σ	29b. Signature and trib effecting	d		-0	1	icense	- 46	()			signed (Month	
		1 / Krill		PAC			HY	088	7		1100	4-14, 8	UUB
3H-4		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	11	7.1	10	M.I.	2/7	40	
	tate	31. Date filed (Month, Day, Year)		strar's Signa	ture	d com	H.	14	vy.	hara a	~ ! 4	1 -	
Regis	strar	MAY 17	2006	Separ 1	B. S.	will							

			. 101	epartment of Health and Mental Hyd Certificate of Death	giene Reg. No.2006 17086
À	Physici		1. Decedent's Name (First, Middle, Last) ELEANCR EMGRY	2. Date of Dea Month	ath Day Year 3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)	4b, City, Town, or Location of Death	4c. County of Death WASHINGTON
18	Funeral Director		5. Social Security Number, 19 6. Sex 1 M 2 F 7. Age (In yrs. last bintho	Months Days Hours Min (Month Da	9. Birthplace (State or Foreign Country) North Carolina
	aryland show dat	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o		10d. Inside City Limits 1 ☐ Yes 2 [★No
	r 28a-f	recto	Maryland Washington 10e. Street and Number	Hancock 10f. Zip Code	10g. Citizen of What Country?
	23a o	aiD	14615 Bain Rd.	21750	U.S.A.
036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or tems 23a or 28a-f show event, the Medical Evarring must be notified at	by Funeral Directo	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No If Yes, Give 3 🛣 Widowed 4 ☐ Divorced Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Se	ecedent's Usual Occupation Give kind of work done during most of working te. DO NOT use retired) ccretary/bookkeeper	excavating drains & contractor/ sewers
Maryland 2	2 should be filed withi and Mental Hygiene. is marked other then sumatic event, the M	To Be Co	Maiden Sumame)		
Mary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			Mailing Address (Street and Number or Rural Route Number of Bain Rd. Hancock, MD	
Baltimore,	ages 1 and 3 int of Health t: if item 27 y or other to		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place) Cemetery 5/14/2006	20c. Location - City or Town, State Burtonsville, MD
Baltir	permit. Pages Department of Inportant: If ite any injury or of		21. Signature of uneral Service Locars is	uneral Home	
100 m	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	· · · · · · · · · · · · · · · · · · ·	, , , , , , , , , , , , , , , , , , , ,
	/Medical Examiner		Due to (or as a consequence of):		
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
8760,	icate be executed physician and s the burial-transit				
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed rideath. sector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
	uires that n signed b ild be deta	Ď	DIACCTC ANCILLY C ISCHED	LA CARNON 1	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Vital Records,	The law require cate has been six page 2 should b	Completed	HYPENTENSION RENN		
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only o	nne)
of	iding Phys th. : After this of funeral dir	tion: To	1 Yes 2 No 1105/161 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of Injury (Month, Day Year) Inju 2 Accident investigation	ne of 28c. Injury at 28d. Describe h	dence 6 □Other (Specify) now injury occurred
Division	in Sign	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical ((Check only one) Certifying Physician: To the best stray is swiledged on the control of the basis of examination and/o and manner stated.	or investigation, in my opinion, death occurred at the time, or investigation, in my opinion, death occurred at the time, or	cause(s) and marker as stated date and place, and due to the cause(s)
		M	29b. Signature and title of certifier BRIAN R STA	D SS 17 MD	29d. Date signed (Month, Day, Year)
	MEH		30. Name and a ress of person who completed cause of death (Item 23a) (Ty	The second secon	D Brian R. STANLEY, M.)
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 2 2006 32. Registrar's Signature	Secret 1	

			For	State of Maryla	nd / Departm	ent of Health and	Mental Hygier	ne	e same die eine total
			1 - Stata Ragistrar		Certific	ate of Death	Reg. I	10.2005	17087
	Physici	an	1. Decedent's Name (First, Middle, L			F11 - 44	I/N	Day Year	3. Time of Death
1	/Medic		4a. Facility Name (Inot institution, g		, 4b. C	ity, Town, or Location of Dea		10 2006 4c. County of Death	2:11
	Exami	iei	The Johns Ho	opkins Hosa	Pital B	5a Himory	. city	•	
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs	Mont	nder 1 Year If Under 24 Hrs hs Days Hours Min		9. Birthpla Countr	ace (State or Foreign
	Director		217-69-9283 Usual Residence of Decedent	1	Yrs.			2004 MARYI	AND
	yland		10a. State 10b. County	10c. C	ity, Town or Location			100	d. Inside City Limits
	e Mar	ctor	MD PRINCE	GEORGE'S	LAUREL				1 X Yes 2□No
	hours after death with the Maryland tural, or Iteme 23a or 28a-f ehow al Examinat must be notified at	Funeral Director	10e. Street and Number		10f.	Zip Code	10g. (Citizen of What Countr	γ?
	e 23e	era i	11424 LAUREL WAI	X DRIVE 12. Was Decedent Ever in L	IS 12 Was Do	20708	Specify Ves or No.	U.S.A. 14. Race - American	n ladian
'	fter de	Fun	11. Marital Status 1 ▼ Never Married 2 ☐ Married	Armed Forces?		ecedent of Hispanic Origin? (specify Cuban, Mexican, Puer	rto Rican, etc.)	Black, White, et	tc.
93	ai', o	<u>م</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 2 X No Specify:		Specify: BLA	LCK
21215-0036	2 E H	Completed	15. Decedent's (Specify only highest of		16a. Decedent's U	work done during most of wo	orking 16b.	Kind of Business/Indu	ıstry
121	within ene. then.	gu	Elementary/Secondary (0-12)	College (1-4or 5+)	NONE	T use retired)		NONE	
	Hygi Other	0	17. Father's Name (First, Middle, La	st)	NONL	18. Mother's Na	me (First, Middle, Maid		
/lan		To B	PHILLIP ROBINS	SON		KRYS	TLE ELLIO	T	
Maryland	d 2 should th and Mer 7 ie marke traumatic	ľ	19a. Informant's Name/Relationship	(Type, Print) PTT/MOTHER		ress (Street and Number or R			
-	s 1 and if Health item 27 other to		KRYSTLE ELLIC		Place of Disposition (UREL WALK DR.		Location - City or Tow	0708
Baltimore,	8 = 5		1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, crematory	or other place)		ENTWOOD, MA	
ati.	교원들 .	1	4 □Donation 5 □Other (Special Signature of unglat Service Lie			1	.B. JENKINS		
ä	Depa impo any i				7474	LANDOVER ROA			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dealy one cause on each line.	ath. Do not enter the r	node of dying, such as cardia	ac or respiratory arrest,	i i	Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition resulting in death)	- Neuro	blasto	ma			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):				7
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quente of).				
	cuted	Examiner	Cause (Disease or injury that initiated events	С.					
Ö,	sate be executed bhysicien and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
8760,	physic physic the b	dical		d					
9 X	death certific: ie attending pl	/Med	IF FEMALE:	23c. If yes, outcome of pregn	nancv			22d Date of deliver	
Вох	atten d for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of delivery Month D	y Day Year
o.	the che	Physician/M	9 Unknown	9 Unknown					
s, P	9 20	ру Р	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	ng cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ord	w requir been si should I	ted	Done In	arrow Ira	insplan	T	1 🗆 Yes	2 No 3 Probab	oly 4 □Unknown
Sec.	e law hes b je 2 sl	Completed	Veno	clusive (disease	٥	24a. Was an autopsy performed?	24b. Were autops prior to comp death?	sy findings available pletion of cause of
a		e Co	Renal	tailure			1□ Yes 2 N		K No
Ξ	9 9 9	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2	☐ ER/Outpatient 3☐	Other	hath Check only one Home 5 ☐ Residence	6 Other (Security)	
٥	ding Phys th. After this of funeral dir		27. Manger of Peath	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
ior	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigat	ion	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	F 5 F C	Certification;	3 Suicide 6 Could not 4 Homicide determine			tory, office	28f. Location (Street: City or Town, Sta	and Number or Rural F ite)	Route Number,
	Hospital (4 hours al Funeral D	S	29s Centifier (Vontitying)	Physician: To the best of my kn	Owlishe Alash www.	red of the time white and class	and due to the ease	et and season season	nd.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	dical	(Check only 2 Medical Ex	aminer: On the basis of examin and manner stated.	ation and/or investigat	tion, in my opinion, death occ	urred at the time, date a	nd place, and due to the	ne cause(s)
-	To the To the Complex complex	Me	29b. Signature and title of certifier			29c. License number		ate signed (Month, Da	ty, Year)
			mor	- 8:7	MO	RES-0	06 M	ay 10	2006
R	(1)		30. Name and address of person wh		m 23a) (Type, Print)	LILLCO GL	(2) (1)	22.7	NEW G
	Sta	10	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ou IV	Wolfe St.	Bultin	ore mi	211187
	Registr		MAY 1 7 201		hout !	-			

			1 - For State Registrar	State of M	/larylan				lealth a Death	and M		iene	000	49
	Physici	an	Decedent's Name (First, Middle, Last				·		-		2. Date of Dea Month	h Day	Year	M
	/Medic Examin		Heather Angel Fm 4a. Facility Name (If not institution, give		r)		4b. City	, Town, or	r Location o		May 12,		ounty of De	11:20 P
	LXuillii		15008 Nashua Lan	е				Bowi	е			Pri	nce Ge	eorge's
	Funeral Director		5. Social Security Number 6. Se 242–56–9209	x 7. /	Age (In yrs. 68	last birthday) Yrs.	If Und Months	Days	tf Under 2 Hours	Min.	8. Date of Birth (Month, Day) Feb.12,	Year) 1938		irthplace (State or Foreign Country) Tyville,NC
	Maryland f ehow	or	Usuet Residence of Decedent 10a. State 10b. County Maryland Prince G	eorge's		y, Town or Lo	ocation							10d. Inside City Limits 1 √2 Yes 2 □ No
	128a-	Director	10e. Street and Number				10f. Z	ip Code			1	0g. Citize	en of What (Country?
	th with		15008 Nashua Lan	е				20	716			Ţ	JSA	
020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Department: If them 27 is marked other then "neturel", or iteme 23a or 28a-f show eny injury or other treumatic event, if a Medical Exactical must be notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? XNo			edent of H ecify Cuba 2 No	ispanic Orig in, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		Black, Wh	nerican Indian, nite, etc. erican Indian
2	in 72 hou n neture	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Dece (Give life.	kind of w	ual Occup rork done i use retired	during most	of working	g	16b. Kin	d of Busines	ss/Industry
7 7	d withing glene.	mo	Elementary/Secondary (0-12)	College (1-4c	r 5+)	Nurse						I	Pvt.	
משם	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) General Stephe	ns					18. Mother		(First, Middle, I			
_	and 2 should leatth and Meni n 27 le marke her treumatic		19a. Informant's Name/Retationship (7) Ronnie Embry/ H						and Numbe a Lane		Route Number Wie, M		Town, State)716	, Zip Code)
ע	Pages 1 and neut of Heart If Item		20a. Method of Disposition 1 🔯 Burial 2 Cremation 3 🗔 4 Donation 5 Other (Specify)		te	Place of Dispo cem <i>etery,</i> crei	matory or	other place			/2006		ation-City or rel, M	or Town, State
Daltimor	permit. Departir Importa eny inju		21. Signature of Funeral Service Licens	Pous	el	22	2. Name :	and Addre	ss of Facility	Bea]	ll Funei	cal H	Home 207	15
ı	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each	line.	th. Do not end					respiratory arr	est,		Approximate Interval Between Onset and Death 1 month
	/Medical Examiner		resulting in death)	Due to (or	as a conseq						ng			3 yrs.
1	be executed iicien and burial-transit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq		-							
6/00,	ate be ex hysicien a the burial	dicai E	L. Control of the con	d	as a conseq	quence or):		-						
O. BOX 0	v requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnant 9 □ Unknowr	2 Feta	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)	r			23	3d. Date of d Month	lelivery Day Year
ds, F.	requires thet the reen signed by th hould be detache	ğ	Part II. Other significant conditions co	ntributing to death	but not res	sulting in the u	nderlying	cause giv	en in Part I.				e contribute No 3∑∏I	to the cause of death? Probably 4 Unknown
•	The law requir ete hes been si page 2 should	Completed									24a. Was a autops perform	n ned? 200 No	24b. Were a prior to death?	autopsy findings available o completion of cause of open as 2 No
<u> </u>	cian: ertific ector,	Be (25. Was case referred to medical examiner?	1				104		of Death	(Check only on	θ)		
5	Physi this c	٠ <u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospitat: 1 ☐ tnpa 28a. Date of li		ER/Outpatier 28b. Time o			4 🔲 1901		8d. Describe ho			pecify)
0	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м	28c. Injur Wor	k? Yes 2 □N		54. 55551155 TK	,	00001100	
DIVISION OF	if or Attention after deal	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of building,	tnjury - At h etc. (Specii	ome, farm, str	reet, facto	ry, office		2	8f. Location (Si City or Town	reet and n, State)	Number or I	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 butus after death, within 24 butus after death. To the Funaral Director: Attenthis certificate has completely filled in by the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director.	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the be inar: On the basis and manner	of examina	owledge, deat ation and/or in	h occurre	d at the tir	ne, date and pinion, deat	d place, a	nd due to the cand at the time, d	ause(s) a ate and p	ind manner a	as stated. ue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	11	-0		2	9c. Licens	e number	H. 10.1	2	9d. Date	signed (Moi	nth, Day, Year)
	7		I stoly a	Leper)			D 00	17368			May	15, 2	006
)_	(6)		30. Name and address of person who c		f death (tter									
	9		Stanley A. Schwart 31. Date filed (Month, Day, Year)		strar's Signa	ature	2101	Medi	cal Pa	ark [r. Silv	er S	pring	, MD 20907
	Sta Registr		MAY 1 7 2006	22. Hegi			12							

06-03161 James W. Edmonds

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 17089

		1- For State Registrar					Cert	tificate o	f Dear	h				Reg. No.	6-	UU	U	100
Physicia dical Exami	an/	1. Decedent's Nam JAMES	e (First, Midd W •		ONDS							1	Date of De Month May 10 ,	eath Day	Yea		3 Time of Dea 1133 hrs	
		4a. Facility Name (11904 Rust		_	treet and nu	ımber)	_			Town, or L nantown	ocation of			М	County o	nery		
Funeral Director		5. Social Security N 218-19-09		6. Sex	2_F		In yrs, Ia 23	st birthday) Yrs	Mont	er 1 Year ns Days	If Under Hours	Min	8. Date of B	,	· · · · · · · · ·	Foreign	nplace (State of Mingto	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funer	4 Donation 5	mber stic Fa ed 2 M 4 Div ducation (Spe ondary (0-12) (First, Middle . Edmon ame/Relations a A . T: sposition X Cremation i Other S	arm arried for arried for arried for arried for arried for arried for arrived for arrived for arrived for arrived for arrived for a for arrived for ar	Road 2. Was Dec Armed Fri 1 Yes, Give Yea, Dates: College (1 4 e, Print) Removal fri	cedent Evorces? 2 X ar de completion (1-4 or 5+)	Ge: Ver in U.S No eted)) 20b. P	16a. Deceder during m Stude 19b. Mailin 1190 lace of Disposementory or oter tropoli	as Decederes, spec Yes 2 At's Usualost of wordent g Addres 04 Ri Sition (Naher place tan	20- ent of Hisp fy Cuban, No Occupatic rking life. I	Mexican, F specify on (Give kin DO NOT u 8.Mother's Patri and Numb Farm etery,	Name (Ficial Puer or Rurn Rd. May 2006	k done irst, Middle A. Po al Route No Gern Date 12,	Uni 16b. K C Maiden Soore umber, Cithanto 20c. L A1	White Specify: ind of Bus olle; Surname) sy or Town wn, I ocation -	Americ, etc. Whi siness/In ge Age City or 1 dria	es an Indian, Bla te dustry	2 X No
Physician /Medical		21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App														Md. 20 Approximate Between On Deat	Interval iset and	
760, froate be executed physician and the burial - transit	edical Examiner	Sequentially list or if any, leading to ir cause. Enter Unde (Disease or injury events resulting in	mmediate erlying Cause that initiated death) Last	c. Du	e to (or as a													
	Σ	IF FEMALE: 23b. Was decedent past 12 month: 1 Yes 2 Part II. Other sign	s? No 9 Un	ne known	9 Unkn	oirth nant at tin own	ne of dea	2 Feath 5 Of	ther (Spe	cify)	Ectopic p				. Date of o	Da	ay Y	ear
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certify hours after death Funeral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use as	Complete	25. Was case refe	rred to modes							26 Plane	of Death (C	Chack and	24a. Wa auto peri 1 ✓ Yes	s an opsy formed?	24b, W	ere auto	opsy findings ampletion of ca	available
Vital ysician his certi director	Be c	examiner?			pital: 1	Inpatient	2	ER/Outpatient	3 1		thor: ==		Home 5	Resider	nce 6 🗸	Other:	Scene	
ision of Vi Attending Physi or death rector: After this by the funeral dir	tion: To	1 Yes 27. Manner of Dea 1 Natural	5 Pen	ding stigation	28a. Date FOUND May 10	of Injury Day Year	$\overline{}$	28b. Time of FOUND: 1133 hrs		28c. Injury		28	Bd. Describe ubject sh	how inju		~	000110	
Division of the bours after de the principle of the princ	Certification	2 Accident 3 Suicide 4 Homicide	6 Cou	Id not be rmined		e of Injur	-	me, farm, stre	et, factor	/, office bu	ilding, etc.		or Town.	State)			al Route Numb town, MD	per, City
To the Hos within 24 hr To the Fun	Medical (29a. Certifier (Check only one) 2	Medical Exa	ı mi ner:0		of examin	_	e, death occu nd/or investiga	tion, in m	y opinion,	death occu			e and plac	ce, and du	e to the	cause(s)	
1	Σ	29b. Signature and	title of certifi	er)	La	eQ.	ai	_	29	c. License O.C.M					11, 200		h, Day, Year)	
		30. Name and add Carol Allan			Medical		,	^{23a)} 111 Penn	Street,	Baltimo	re, MD 2	21201						
S Regis	tate trar	31. Date filed (Mg	AY ^{Pay} ,Teg	200	6 32 8	egistrar's	Signatur	A See	New York									

			. 101	artment of Health and Me	ental Hygiene Reg. No.	71116 1 / 11 4 11
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Dorothy Lee Fields		2. Date of Death Month Day May 14, 20	3. Time of Death 3:07 P M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number) Civista Medical Center	4b. City, Town, or Location of Death La Plata		County of Death Charles
	Funeral Director		5. Social Security Number 226-38-8348 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 70 Yrs.	Months Days Hours Min	B. Date of Birth (Month, Day, Year) PCC. 11, 19	9. Birthplace (State or Foreign Country) Washington DC
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	he Mar	ector	Maryland Charles Bryant 10e. Street and Number	OWN 10f. Zip Code	10g Citi	1 ☐ Yes 2 No izen of What Country?
	Maith 138 or 1	ai Dir	5480 Huckleberry Drive	20617	Tog. On	USA
36	irs after deet ii', or items 2 xaminer mu	by Funeral Director		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 ia marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinar must be multified at 90ce.	Completed	(Specify only highest grade completed) (Given life.	edent's Usual Occupation s kind of work done during most of working DO NOT use retired) OKKEEPET	9	ind of Business/Industry
nd 2	al Hygid d other avent, il	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden	
<u>yla</u>	hould to d Ment marked matic s	ှ	Arthur Raymond Crowther 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural in	Elise Bray	r Town, State, Zip Code)
, Ma	is 1 and 2 soft Health an Itam 27 ia		Brenda M. Hartmeyer - Daughter 5480	Huckleberry Dr., Br	yantown, N	MD 20617
nore	ages 1 nt of He I: If Itan / or oth		20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State Indian State	ምየ <i>የእና የ</i> ተምያያ ው i 1 1		ocation - City or Town, State
Baltin	permit. P Departme Importent any injury		21. Signature Funeral Service Lipersee M00053		3035 01d Wa	ashington Rd. aldorf, MD 20604
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate Interval Between
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Onset and Death
	Examiner			owel		
	nsit	Examiner	Sequentially list conditions, if any, leading to state underlying cause. Enter Underlying Cause (Disease or injury	owel Bovel disease		
8760,	death certificate be executed e attending physicien and d for use as the burial-transit	ical Exa	that inditated events resulting in death) Last C. Due to (or as a consequence of):			
Ö	tificate ng phys as the		d.			
P.O. Box		Physician/Med		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
	law requires that the es been signed by th 2 should be detache	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
al Records,	The ete h	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2.2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
of Vital	Physician: 1 this certificer ral director, p	To Be	25. Was case referred to medical examiner? 1 \(\) Yes \(\) No \(\) Hospital: \(\) Inpatient \(2 \) ER/Outpatie	26. Place of Death (ont 3 DOA Other: 4 Nursing Home	<i>Check only one)</i> e 5 ☐ Residence (6 □Other (Specify)
o uc	ling After une		27. Manner of Death 1. Natural 5 ☐ Pending (Month, Day Year) 2. ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	d. Describe how injur	y occurred
Division	or A lifter Diraci	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		8f. Location (Street and City or Town, State	d Number or Rural Route Number,)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or and manner stated.			
	To the within 2 To the comple	Me	29b. Signature and title certifier	29c. License number 2005 37 19		e signed (Month, Day, Year)
6	A TO IL	N	30. Name and address of person who completed cause of death (Item 23a) (Type		1 11 1	5 MA 20502
1	NO ID Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TOffice Kood,	Nalder T	MD 2060.7
	Regist	rar	MAY 1 6 200 Klosus 15.	books		

			1 - For State Registrar	State of	f Marylar		artment of F rtificate of		and M		giene Reg. No	006	17091
	Physici		1. Decedent's Name (First, Middle, I Carmella D. Fie	_						2. Date of Dea Month MaV	Day	^{Year} 2006	3. Time of Death 5:00 a M
100	/Medic Examin		4a. Facility Name (If not institution, g		nber)		4b. City, Town, o	r Location o	of Death			ounty of Death	
	**		40 Glen Oak Cour	t				inste				Carro	11
١.	Funeral		Social Security Number 6.	Sex 1 ☐ M 2 🛣	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp Coul	place (State or Foreign ntry)
	Director		167-22-4007			81 Yrs.				July 1	6 192	4	PA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	Mary	ō	MD Car	roll		Wes	stminster	•					1 ☐ Yes 2 🛣 No
	28a	Director	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Coul	ntry?
	3a or		40 Glen Oak Co	nirt.			2	1158				USA	
	death me 2	Funeral	11. Marital Status	12. Was Dece		J.S. 13.	Was Decedent of H		gin? (Spe	cify Yes or No		Race - Americ	
9	or its		1 Never Married 2 Married	Armed For 1 Tes If Yes, Giv	2 No		1 ☐ Yes 2 ☐ ★ o	Specify:	i, Puerto r	wan, etc.)		Black, White,	etc.
<u>8</u>	ours raf,	d by	3 XWidowed 4 ☐ Divorced	Year or Da	ates:		10 163 20 X 0	эрвспу.			St	ecify: Wh	nite
2	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow fra Madical Examiner must be notillisd at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Occup kind of work done	durina most	t of working	ng	16b. Kind	of Business/In	dustry
12	Mithin Men Men	m	Elementary/Secondary (0-12)	Coilege (1	-4or 5+)	III e.	DO NOT use retire	•			_	ra Hame	
5	Hygie Hygie thert int, in	ပိ	12 17. Father's Name (First, Middle, La	st)			Homemak		r's Name	(First, Middle,		wn Home	2
auc	ontail ed ol) Be	Anthony Pantoni							Panza	Walasti Da	777477	
Maryland 21215-0036	mari mati	၉	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street				r. City or T	own, State, Zic	Code)
Z	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, I're Medical Exemitien must be notified at		Frank Fieni/son	,,,,,			len Oak (tminste			
ē,	f Head		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place	= 1		ate		tion - City or To	
Ë			1 ☑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	∑ Removal from : cify)			Cemetery	- 5	5/20/	2006	Bear	ver, PA	
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature Ineral Service Lic	, P.A.	21157								
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that co	aused the dea	th. Do not ent	er the mode of dyir	ng, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mo	12ch2t	14 (6	reihoma	(un	4				Onset and Death
	/Medical		resulting in death)	a	or as a consec		1011010)				1 4 41)
П	Examiner		Sequentially list conditions	b									
	₽ ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consec	quence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
760,	ate be executed obysician and the burial-transit		resulting in death, cast	Due to (or as a consec	quence or):							
œ.	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical		d									
9 ×	eath certifica attending ph for use as th	/Me	IF FEMALE:	23c. If yes, out	come of prean	ancv					00-	Data of dalar	
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 ☐ Feta ant at time of o	at death 3	Ectopic pregnancy Other (specify)	1			230	I. Date of delive Month	Day Year
o	the d	ıysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unkno									
٥	ires that the de signed by the a I be detached f		Part II. Other significant conditions	contributing to de	eath but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to the	ne cause of death?
Records,	n sign	d by								1 🗆 Y	es 2	lo 3 ☐ Prot	oably 4 Unknown
00	aw requir is been si 2 should	lete								24a. Was		4b. Were auto	psy findings available
Be	The tay te has age 2	Completed								autop	med?	death?	mpletion of cause of 2□ No
ta	ysician: The is certificate hadirector, page	0	25. Was case referred to medical					26. Place	of Death	(Check only o	ne)	1 🗆 Yes	2010
<u> </u>	Physici this cer al direc	To B	examiner? 1 □ Yes 2 No	Hospital:	npatient 2] ER/Outpatier	nt 3 DOA Oth	000	rsing Horr			Other (Specifi	y)
0	Attending Physician: r death. ector: After this certifice by the funeral director, is		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of	of Injury th, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	2	8d. Describe h	ow injury o	ccurred	
<u>0</u>	endir sath. or: Al he fu	atic	2 Accident investigat	ion				Yes 2 N	No				
Division of Vital	Hospital or Attence Hours after death Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 289. Place	of Injury - At h ng, etc. <i>(Speci</i>		eet, factory, office		2	8f. Location (S City or Tow		lumber or Rura	l Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		aminer: On the ba			h occurred at the tir vestigation, in my c						
	To the Vithin 2.	Σ	29b. Signature and title of certified	1/1/1 1	20		29c. Licens	e number			29d. Date s	igned (Month,	Day, Year)
)	WIL		16	VV I VY)i_)		175	3184			11/19	16,2	006
	W4		30. Name and address of person when	Kushne	5	114 Bu	Print) SIMSS Ce	nft	DAL	Rei	s Hs hu	in, MI	2/136
6	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 6	2006	egistrar's Sign	ature	ands!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 22 per fb 8856 6-1-06 vt.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Ce.	rtificate of Death	Reg	_{g. No} 2 0 0 6	17093
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Sheila Kay Gallegos		2. Date of Death	2006 Year	3. Time of Death 23:00 P M
1	Examin		4a. Facility Name (If not institution, give street and number) 7968 Aldan Drive	4b. City, Town, or Location of Deat Chestertown		4c. County of Deat Kent	th
	Funeral Director		5. Social Security Number 042-34-1221 6. Sex 1 M 2 X F 63 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birt 1942	hplace (State or Foreign buntry) MI
	show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	8e-f	Director	MD Kent Cheste				1 Yes 2 No
	ath with the 23a or 2 until Le m	ral Dire	10e. Street and Number 7968 Aldan Drive	10f. Zip Code 21620		g. Citizen of What Co USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or Items 23s or 28e-f show eny injury or other treumatic event, I're Medical Ever in art must be rivilled at once.	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: W1	
5-0	72 hc	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16	6b. Kind of Business/	Industry
121	vithin ne. hen	Completed		DO NOT use retired) amatician		National S	Security
	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Ma		
/an	uld be Nental rked (To B	Russell McLaughlin	Ethyl I	mogene Sh	arp	
Maryland	nd 2 should alth and M 27 is maintreumaint.			ng Address <i>(Street and Number or Rt</i> Aldan Dr., Chest			Zip Code)
Baltimore,	Pages 1 a lent of Hea nt: If item ry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	osition (Name of matory or other place) ke Gremation 05/1		Dc. Location - City or tevensvill	
Balti	permit. Departm Importe eny inju		21. Signature of Euneral Service Licensee	2. Name and Address of Facility Fellows, Helfenbe 130 Speer Read.	in and Ne	wnam Fuen _Chestert	al Hone own Md21620
68760,	Physician /Medical Examine physician and se as the pnual-transit e a	Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CARDIC RESPIR Due to (or as a consequence of): Due to (or as a consequence of): MALI GNANT Due to (or as a consequence of):	ARCINOMA			Interval Between Onset and Death
P.O. Box 68	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the buriat-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
	uires that signed by Id be deta		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
I Records,	The law ate has b page 2 si	Completed by			24a. Was an autopsy performe	prior to c ed? death?	topsy findings available completion of cause of
Vital	icien: The certificate rector, pag	Be (25. Was case referred to medical examiner?		ath (Check only one)		
Division of \	ling Ph	2	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	76477878787	lome 5 Residence 28d. Describe how	ce 6 □Other (Spec rinjury occurred	cify)
Divisi	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in it.	edical	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, deatt 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To t withi To t	Σ	29b. Signalure and title of certifier	29c. License number D00570		d. Date signed (Month	
(C	ms		30. Name and address of person who completed cause of death (Item 23a) (Type, TOWN J. LAFE/2LA, MD 100	Print) BROWN ST.	CHEST	ERTOWN	mD
•	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's signature	A Section			

			For State Registrar		State of	Maryla		oartmer e <i>rtificat</i>				fental Hy	gien/ Reg. N	2111	16	7	094
	_		Decedent's Name (First, Michael Control of the	idle, Last	")				0. 1		-	2. Date of D		10.		3. Time	of Death
	Physici		1 - 1		60/0							Month	12	ay 2.~	Year	050	
1	/Medic		4a. Facility Name (If not institut	ion aive			3	4b City	Town, or	Location	of Death	3		c. County o			
	Examin	er	- va. r doing riamo (ii riot indirial			50.7		40. Ony,		LUULIN	. 01 000001		'	Co County o	\		
			5. Social Security Number	6. Se	x 7	Age //n vr	s. last birthda	y) ff Unda	r 1 Year	If Unde	or 24 Hrs.	8. Date of B	idh	1,100	-	mer /State	or Foreign
	Funeral Director				_ М 2□ F	. rigo (iii yii	63 Yrs.	Months	Days	Hours		(Month, D	ay Yea	1942	Cour	ssachi	setts
			015-32-4612 Usual Residence of Decedent	4	Λ		03					beptt		17.14			
	land		10a. State 10b. Cour	ity		10c. 0	City, Town or	Location							1	0d. fnside	City Limits
	Mary	ō	Maryland Mont	gome	ry	Ro	ockvil:	Le								1 ₹ Ye	s 2 No
	288 288	ect	10e. Street and Number					10f. Zip	. Code				10a C	itizen of W	nat Cour	ntry?	
	M O M	<u></u>	6121 Montrose	Roa	d				2085	52			-	J. S.			
	within 72 hours elter death with the Maryland ene. than "natural", or items 23a or 28a-f ehow ha Madical Examinar must be notified at	Funeral Director	44.34.00100		12. Was Deced	ant Ever in	110 11	2 Mac Dose			rigin? (Cn.	noite Vac or M				an Indian,	
	iten d	Ę.	11. Marital Status 1 XNever Married 2 M	arriad	Armed Ford	es?	0.3.	If Yes, spe	city Cuba	n, Mexica	an, Puerto	ecify Yes or N Rican, etc.)	0-		White,	etc.	
36	rs eff	by F	3 ☐ Widowed 4 ☐ Divorc		If Yes, Give	_		1 Tes	2 🕅 No	Specify	y:			Specify:	V	Vhite	
21215-0036	hou	be	15. Deced				162 Do	edent's Usu	al Occupa	tion			166	Kind of Bus	innee/le	dustra	
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12	with and the state of the state	E	Elementary/Secondary (0-12 12 Years)	Coflege (1-	4or 5+)			les.					Ret	ail		
2	be filed within 72 hours effer death with the Marylan tal Hygiene. d other than "natural; or items 23s or 28s-f show event, the Medical Examination must be rediffed at		17. Father's Name (First, Middle	e Last)						18 Moth	ner's Name	e (First, Middle	Maide				
ano		Be	Jospeh Gol		erg					10. 11.01.		Hershm		oamano	,		
Ŝ	should be ind Mental marked o	2	19a. Informant's Name/Relatio				10h Ma	iling Address	/Ctroot o	and Alicent	har as Our	al Route Numb	Cit	Taura C	t- t- T:-	0-4-1	
Maryland	12 sho h and h 7 is ma trauma	1 3	Julien E. Cla			077		•				, Wash					011
d)	s 1 and 2 should t Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	IK -	Accorn		Place of Dis		_	1		Date		Location - C			
ō	ges it of l		1 Burial 2 ☐ Crematio			ate	cemetery, c	ematory or o	other place						•		_
altimore,	tmer tant		4 □ Donation 5 □ Other			Cl	need S				5/16/			shing			J.
Baj	permit. Pages 1 Department of H important: If ite any injury or ot once.		21. Signature of Funeral Service	?	State	tems	us	^{22. Name ai} Danzan 1170 R	nd Addres ISKY-(.ockv:	s of Fact Gold ille	berg Pike	Memori , Rock	a1 (vill	Chapel e, Ma	s, ryla	inc.	20852
			23a. Part1. Enter the disease, shock, or heart failure. L	or comp	lications that car	used the se	ath. Do not e	nter the mod	de of dying	, such a	s cardiac o	or respiratory	errest,			Approxima Interval Be	ate elween
	Physician		Immediate Cause (Final disease or condition						-							Onset and	Death
	/Medical		resulting in death)			r as a conse	equence of):	(CV)	25.2	545	۵						
	Examiner				(2)		06	2	\^.1	3.	1~	5	7 "	2052			
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ó	exection and and right-tr	Exa	resulting in death) Last			r as a conse											
8760,	The law requires that the death certificate be executed are hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai			d												
99	ificate g phys as the	edi		- 1										, -			
Вох	eath certifi attending I for use as	2	IF FEMALE: 23b. Was decedent pregnant	1	23c. If yes, outco			-						23d. Date	of delive	iry	
m	death a atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Pregna	th 2∏Fe ntattime of		I∐Ectopic p I∐ Other <i>(s</i> ;						Mont	h	Day	Year
0	at the de by the a stached	Physician/Me	9 Unknown		9□ Unknov	vn											
٥.	s their	by P	Part II. Other significant cond	itions co	ntributing to dea	th but not re	sulting in the	underlying o	ause give	n in Part	l.	23e. Did	tobacco	use contrib	ute to th	e cause of	death?
Vital Records,	quires n sign ald be	d b	Lung S	ma	35							-92	Yes 2	2 □ No 3	☐ Prob	ably 4]Unknown
Ō	w require been si should b	lete		_								24a. Was	an	24h W	ere auto	psy finding:	e available
Re	The la	Completed	200-1	3-6	Car one							auto	psy ormed?	pri	or to cor ath?	npfetion of	cause of
a	ician: Th certificete ector, pag		05 111									1 ☐ Yes	-25 N	0 1	Yes	2 No	
<u> </u>		Be	25. Was case referred to medi examiner?	-	Hospital:				Othe	-		Check only			_		
ō	Phys this ral di	.T	1 ☐ Yes 2 No 27. Manner of Death	-	1 🗆 Inj		28b. Time		28c. Injury	400347		me 5 Res 28d. Describe				<u>"</u>	
E C	ding h. After tuner	5	Natural 5 ☐ Pen	ding stigation	28a. Date of (Month,	Day Year)	Injury		Work	?ົ ′es 2.[204. 00001100	11041 1111	ary occurred			
Si	Attending in death. ector: After by the funer	ca	3 ☐ Suicide 6 ☐ Cou	ld not be	29a Pface o	f Injuny - At	home, farm,					28f. Location (Street a	nd Number	or Pum	I Courte Mu	mbos
Division	in the o	Certification:	4 Homicide dete	rmined	building	, etc. (Spec	cify)	stroot, ractor	y, onice			City or To	wn, Stai	te)	or riura.	HUUIG NUI	71001,
_	spits ours sera fille		29a. Certifier 15 Certif	vina Phy	sician: To the b	est of my br	nowledge do	ath occurred	at the tim	a data a	nd place	and due to the	cause/:	c) and man	10r 20 c*	atod	
	5 4 J 9	Medical	(Check only 2 Medic	al Exami	ner: On the bas	is of examir	nation and/or	investigation	, in my op	inion, de	ath occurr	ed at the time,	date ar	nd place, an	d due to	the cause	(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certi		_ `				c. License				29d. D	ate signed (Month, I	Day, Year)	
	,- > - 0		12	X	Silowe	>		2	2500	183	M		5	112/06			
			30. Name and address of person	on who o	nmnleted cause	of death (It	am 23a) /T	Print)	7.~- "	~ ~	2.7.			2 -1		~	
			22. Tamb and address of perso					10	- /1			tav 2	>	Mark	508	23 W	-
	Sta	te	31. Date filed (Month, Day, Yea		32. 🔐	gistrar's Sigr	nature	14		- 3	2.25.04	this ?	3				
	Registr		MAY 1	6 2	006	September 1	nature	Back	,								

		For State Registrar			Certifica	ate of De	eath		Reg. N	0.		
Physicia /Medic		Decedent's Name (First, Middle, Last George	J.	Hinna	int			2. Date of De Month May		ay 3	Yeer 200	3. Time of Dea
Examin		4a. Facility Name (If not institution, give					cation of Death	-		c. County	of Death	
Funeral Director		Southern Md Hos 5. Social Security Number 6. Se 578-52-9060	7. Age	(In yrs. last bii 66			Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCT.	th		9 Birth	George place (State or Fo ntry) th Caro
MOI THE		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Li
	ctor	Maryland Prince	George	Upper	Marl	oro						1 Z Yes 2 □
or 26	Director	10e. Street and Number				Zip Code			10g. C	itizen of V		ntry?
8 23e	era	11113 Old Mar	Lboro Pik 12. Was Decedent E			20772	anic Origin? (Spe	oifu Vas or No	. 7	USA 14 Bac		can Indian.
ta nyjana other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2XX Married 3 Widowed 4 □ Divorced	Armed Forces? 1 [2(Yes 2 No If Yes, Give Year or Dates:				anic Origin? (Spe Mexican, Puerto Specify:	Rican, etc.)			k, White,	etc.
ical E		15. Decedent's Edu (Specify only highest grad	ucation		. Decedent's U	sual Occupation	n ing most of works		16b. l	Kind of Bu		
than "c	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		use retired)	ng most of worki ator	ng .		Met	ro.	
off the		17. Father's Name (First, Middle, Last)					I. Mother's Name	(First, Middle	, Maide			
marked o	To Be	Alonzo		Hinna	ant		Donnie				Lof	ton
i i		19a. Informant's Name/Relationship (T) Ruby E. Hinnant		196	Mailing Addr	oss (Street and DId Mar	Number of Aura rlboro lboro, L	Pike	er, City	or Town,	State, Zip	Code)
= 5		20a. Method of Disposition 1 1	Removal from State	20b. Place o cemete	ry, crematory o	vame of or other place)		ate	20c. I	_ocation -	City or To	own, State
important: i eny injury o once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		-	22. Name	and Address of	AC	lams F	une	ral	Hom	Maryla e PA
.= • a		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	\rightarrow	191	2060	5 Aqua	sco Ro	l, Aqua	sco	Maı	ryla	nd 2060
sician edical iminer		shock, or heart tailure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	ple a	resial	intar-	ct					Interval Between Onset and Death
physicion and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d									
On eff	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	n 3 □Ectopio 5 □ Other	c pregnancy (specify)				23d. Dat Mor	e of delive	ery Day Year
gned be de	þ	Part II. Other significant conditions co			n the underlyin							he cause of death
gned be de	1 2	Dibetis.								24h V	Vere auto	psy findings avail
has been s ge 2 should	ompl								osy orm <i>e</i> d?	F 6	rior to co leath?	mpletion of cause
ate has been s page 2 should	Se Completed	25. Was case referred to medical				26	3. Place of Death	autoj perfo 1 Yes	osy ormed? 2 X N	F 6	rior to co	
s certificate has been s lirector, page 2 should		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No			utpatient 3	DOA Other:	4 Nursing Hor	autoj perfo 1 □ Yes (Check only o	osy rmed? 2 (X No	o 1	erior to co leath?	2⊠ No
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grei Director. After this certificate has been s illed in by the funeral director. page 2 should	edical Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day 28e. Place of Injury building, etc. 28ician: To the best of iner: On the basis of and manner state	y - At home, fa (Specify) my knowledge examination an	Time of Injury M arm, street, factor, street,	DOA Cther: 28c. Injury at Work? 1 Yes ony, office ed at the time, ion, in my opini	4 Nursing Hor 2 No date and place, a on, death occurre	autop perfic 1 Yes (Check only of ne 5 Resi 28d. Describe City or Tou and due to the ad at the time,	osy primed? 2 None) dence how inju	6 Othory occurr	orror to colerath; Yes Yes or (Specified)	2 Id No Al Route Number, tated. to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** James T. Honaker 13 2006 11:36 a M May /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Cecil Union Hospital of Cecil County If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X**) M 2□ F 3/3/1938 Director 68 Maryland 218-34-0870 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or Itema 23a or 28a-f show 1 Yes 2 No Maryland Cecil E1kton Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21921 United States 10 Stoney Chase Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gravel Loader Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Laura Hale Jonas Honaker 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trai Ralph Hanaker/Son 10 Stoney Chase Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Hopewell Cemetery May 17,2006 Port Deposit, Maryland 22. Name and Address of Facility Crouch Funeral Home (lake 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Shock Immediate Cause (Final Unknown Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed Therosclorosi attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the aid be detached to Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this : After the 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 20083322 29b. Signature and title Certifier 2 Sachder SMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scule 3B, Elkin MD 2192.1 5 Jachden State Registrar

			1 - For State Registrar	State of Ma	ryland / Depa	artment of I			giene Reg. No.2	0.6	7097
- 2	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month May	Day	Year	3. Time of Death
	/Media	al	Marcus Neil Hors			Ab Cib. Taur			10	2006	0500 A M
	Examir	er	4a. Facility Name (If not institution, give				or Location of Dea Iagerstow			ty of Death	on County
4,00	Funeral	~ -	Washington Count 5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir			lace (State or Foreign
1	Director		N/A	X M 2□F	Yrs.	Months Days	Hours Min 12	May 9			ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		2			Od. Inside City Limits
	Maryl -f sho	to	Maryland Washing	aton	На	gerstown					1 ☐ Yes 2X No
	r 28a	lrec	10e. Street and Number	gcon	IId	10f. Zip Code			10g. Citizen o	What Coun	itry?
	th wit	<u>a</u>	18910 Air View I	Road			21742			U.S.	.A.
	ar dea	nuel	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Ra BI	ace - Americack, White,	
36	rs afte	y F	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	0	1□Yes 2 ZX o	Specify:		Spec	ity: Wh	ite
9	72 hours after death with the Maryland naturs!; or Itame 23a or 28a-f show dical Exart or Itaus to recitified at	Completed by Funeral Director	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	oation		16b. Kind of	Business/Inc	dustry
215	within 7. ene. than "n be Med	ple	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5-	life.	kind of work done DO NOT use retire	during most of wo d)	rking		/-	
21	be filed within 72 hours after death with the Marylan Ital Hygiene. sd other then "naturs!", or itame 23s or 28s-1 show svent, the Medical Examinat must be inclined at	Con				N/A				N/A	
Maryland 21215-0036	ould be fi Mental H arked otl	Be	17. Father's Name (First, Middle, Last) Linford R. Hors	st				me (First, Middle, rolyn J.			Ł
Ž	E B E E	ပ	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street					
	alth ar 27 is 1r treu		Linford R. Horst	t (father)		0 Air Vi					
ore,	of Heal of Heal fitsm 2 r other		20a. Method of Disposition 1X Burial 2 Cremation 3		20b. Place of Dispo	sition (Name of	ce)	Date	20c. Location		
Ĕ	Pag ment ent: h		4 Donation 5 Other (Specify,		Mt. Olîve Church Ce	Mennoni netery	te 5-1:	3–2006	Maugan	sville	e Maryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If itsm 2 sny injury or othar		21. Signature of Funeral Service Licens	1/ 7	22	2. Name and Addre			-		
Sq.	40200		23a. Part1. Enter the disease, or comp	y. Xlly	the death. Do not out	1331 Eas	tern Blv	d. N. Hag	gerstow	n Mary	yland 21742 Approximate
	7 3		shock, or heart failure. List only o	one cause on each lin	e.	C 1 (1 1	-L.		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to for as a	2+hal	tetal	Skele	tay (372 P10	45101	
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	ecuter and -trans	Examiner		C						-	
8760,	ate be executed hysician and the burial-transit	Ical E		Due to (or as a	consequence of):					1	
687	ficate physis the			d							
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		7F-4i			23d. D	ate of deliver	ry
	deat he atte	sicia	in the past 12 months? 1 Tyes 2 No	4☐Pregnant at t		Ectopic pregnanc Other (specify)	у		M		Day Year
P.O.	at the	Phy	9 Unknown					00 5:11	. 03		0 2006
	uires that the de signed by the a Id be detached f	l by	Part II. Other significant conditions co	introduing to death bu	t not resulting in the u	nderlying cause giv	en in Paπ I.	238. Did to	· V		e cause of death? ably 4 Dunknown
Records,	w requir been si should l	Completed						24a. Was			
Re	he tav e has	dmo						autop perfo		prior to com death?	osy findings available inpletion of cause of
	ysicien: The is certificate hadirector, page	Be Co	25. Was case referred to medical				26 Place of De	1)X Yes ath Check only o	2 No	1 Yes	2)8-No
Ţ	Physici this cer al direct	To B	examiner? 1 ☐ Yes 2 💓 No	Hospital: 1 XInpatier	nt 2 ER/Outpatien	t 3 DOA Ott	or	fome 5 Resid		her (Specify)
0	Attending Physicien: r death. sctor: After this certifica by the funeral director.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Time of	28c. Injui Wor		28d. Describe h			
sio	tendi Jeath. tor: A the fu	cath	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
Division of Vital	after of Direc	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tox		ber or Rural	Route Number,
_	Hospitel 14 hours a Funerel (29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowledge, death	n occurred at the tir	me, date and place	a, and due to the	cause(s) and m	ianner as sta	ated.
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral.	edical	(Check only 2 Medical Exam	iner: On the basis of and manner stat	examination and/or inv	vestigation, in my o	pinion, death occu	urred at the time, o	date and place	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	7 11-	\	29c. Licens			29d. Date sign	/	
ŀ			1/Siconto	7- /1.	D,	57	882		05/1	10120	XC16
_	iLo		30. Name and address of person who	impleted cause of de	1/1	Print)	MACLI	natan	Cours.	4 1	Lacrital
91	H-O Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	12 − MOT r's Signature	iou	MANI	myton	Coun.	17	MAILA
	Registr			2006	w B. D.	parker					
				100							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1:05 A James Irving Horne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Doctors Community Hospital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | July 27, 1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F Yrs. 238-28-8334 83 North Carolina Director Usual Residence of Decedent Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 10a. State ir than "natural", or Items 23a or 28a-f ehov tre Medical Examinar must be southed at 1X Yes 2 No Maryland Prince George's College Park Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3426 Duke Street 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1X□Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NCT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Pharmaceutical Sales Health Care marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F is marked of Be 99 John Calvin Horne Della Ann Draughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s f Health an Depertment of Health Important: If Item 27 3426 Duke Street, College Park, MD 20740 Botty R. Horno/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ⊠Burial 2 □ Cremation 3 □ Removal from State May 2006 18, Fort Lincoln Cemetery iniury 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral S wice Licen e Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, Md 20501 Ulu 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) nultiple muel /Medical Due to (or as a co nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending for use as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the Ö 9 Unknown 9 Unknown ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy ormed? 2X No certificate 2 No 1 Yes Division of Vital 1 Yes 25. Was case referred to medical funeral director 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 - Homicide Hospital or filled 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD31357 5+1 30. Name and address of person death (Hem 23a) (Type, Print) Luck Road 600a inda Was 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			, FUI	eartment of Health and Mertificate of Death	lental Hygie	6000	17099
	0		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Elizabeth F. Holmberg			2 2006	2:45 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			716 Carr Avenue	Rockville		Montgo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	place (State or Foreign intry)
	Director		579-18-4101		June 5,19	921 Wash	ington DC
	land		10a. State 10b. County 10c. City, Town or t	ocation			10d. Inside City Limits
	Mary	ō	MD Montgomery R	ockville			1 ☐ Yes 2 X No
	the 28e	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?
	3a or		716 Carr Avenue	20850	U	nited Sta	tes
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto		14. Race - Amer	ican Indian,
9	after or Ite		1 Never Married 2 Married 1 ☐ Yes 2 🕅 No	1 ☐ Yes 2 ☒ No Specify:	rican, etc.)	Black, White	White
2	raf',	d by	3 Mg Widowed 4 □ Divorced If Yes, Give Year or Dates:	TE Tes Zigg NO Specify.		Зреспу.	wiitre
, L	72 h "natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16l	b. Kind of Business/Ir	ndustry
12	within lene. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)	ookkeeper		Danisina	
i N	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or Hems 23a or 28e-f show ant, the Medical Examinat must be rediffed at		17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	Banking	
anc		Be	Aloysius Fealy		rawford	32	
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygiene, marked other then "natural", or Items 23a or 28e-1 show maric event, the Medical Examinat must be routilled at	ပ		ling Address (Street and Number or Rura		ity or Town State 7	in Code)
Na	d 2 s th an th an trau			4 Ripleys Field Dr			
e)	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked vany injuryog other traumatic av once.		20a Method of Disposition 20b. Place of Disp	position (Name of		c. Location - City or T	
altimore,	t: # is		1 M Burial 2 Cremation 3 Removal from State 3 Cate of	Heaven May	2806		
₹	artme orten injur					Silver Spr	
Ba	Dep Imp		1//	eer Park Drive, Ga		eral Home	
			23a, Part1, Enter the disease, or complications that caused the death. Do not el			0.	Approximate
	Pnysician ·		shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Pancr Due to (or as a consequence of):	eatic Cancer			1 Year
П	Examiner						_===
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of):				
	cutec nd rransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ö,	e exe ilan a urial-	Ë	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d				
9	leath certifica attending plant of for use as t	Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	ath c attend for us	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
P. 0.	the a	ysic	1	Other (specify)			
	that the da led by the detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Division of Vital Records,	signe d be	d by			1 ☐ Yes	2 \$No 3 \super Pro	bably 4 □Unknown
Ö	w requir been si should	Completed			24a. Was an	24h Mara aut	opsy findings available
36	has ge 2	mp			autopsv	prior to co	ompletion of cause of
a	icien: Th certificate ector, pag				performed	No 1 ☐ Yes	2 □ No
Ĭ	Physicien: r this certificated director, in	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		h (Check only one)		
o	Phys r this ral dii	-	27. Manner of Death 17 Natural 5 Pending (Month, Day Year) 18 Natural 5 Pending (Month, Day Year)		28d. Describe how		<i>Ty)</i>
on	Attending Physicien: The r death. ector: Atter this certificate hetor: After this certificate hey the funeral director, page	tior	1X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
/IS	or Attendatter death Director: in by the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office		t and Number or Rur	al Route Number,
á	in Direct	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	state)	
	e Hospital 24 hours a e Funeral I etely filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of conifier	29c. License number		Date signed (Month,	
)	<		I who appre	D42452		May 12, 20	006
	_		30. Name and address of person who completed cases of death (Item 23a) (Type				
			Chitra Rajagopal, 9715 Medical Cen		ockville,	MD 20850	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 16 2006 32. Registrar's Signature	Carle			
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			1 - For State Registrar	State of N	/laryland				lealth a		lental		ene ()	06	17100
	Physici		Decedent's Name (First, Middle, I John H. Heur:								2. Date of Month	of Death	Day	Year	3. Time of Death 8:55 P M
	/Medi Examir		4a. Facility Name (If not institution, g Gladys Spellman Spec			ursing			Location o				4c. County	y of Death	
1	Funeral Director		579-46-8830	.Sex 7.7 1 ☐ M 2 ☐ F	Age (In yrs. Ia	,) If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date (Mont) July	of Birth h Day, Y	1934	Coi	nplace (State or Foreign untry) hington, DC
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exeminat he notified at	eral Director	10e. Street and Number 8403 Quintana	George's Street	N	, Town or L	rroll 10f. Zi	p Code 2078		inin2 (Co	posts Voca		g. Citizen of	USA	10d. Inside City Limits 1 ☐ Yes 2 🏝 No untry?
0036	hours after de tural', or itam	d by Funeral	11. Marital Status 11. Marital Status 12. Never Married 2. Married 3. Widowed 4. Divorced	Armed Force 1	s? X No		If Yes, spo	2 X No	spanic Ori n, Mexicar Specify:	n, Puerto	Rican, etc	c.)	Specif	ck, White y: Whi	s, etc. Lte
d 21215-0036	within 72 ane. than "nai	Completed	15. Decedent's (Specify only highest statementary/Secondary (0·12) 6 17. Father's Name (First, Middle, La	grade completed) College (1-40	r 5+)	(Give life.	dent's Usu kind of w DO NOT (ork done d use retired	during mos rker				Disti Gover	rict nmer	of Columbia
Maryland	2 should and Mer is marke sumatic	To Be	William J. Heur 19a. Informant's Name/Relationship	cich (Type, Print)					Ru and Numbe	ith E	. Mo	rgan Jumber, C	City or Town,	State, Z	
Baltimore, I	Pages 1 and nent of Health satt: if itsm 27		H. Mabel Capacel 20a. Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Special Content of the Content of	☐Removal from Stat	20b. Pla	1440 ace of Disp emetery, cre lar Hi	osition (Na matory or	me of other plac	ө)		ate		ryland c.Location Suit1	City or T	
Balt	Departi Departi Importa any inje		21. Signature of Funeral Service Lic	2000	9	5	00 Ur	niver	sity	Blvd	l, W,	Sil	Home] ver Sp	[nc.	g, MD 20901
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	y one cause on each	ine. is a consequ	ence of):		de of dying	g, such as	cardiac d	or respirato	ory arrest			Approximate Interval Between Onset and Death 6 Weeks
8760,	cate be executed physician and the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ventil	s a consequ	ASTOCI ence of):		Pneu	monia	1					6 Weeks
O. Box 6	the death certifi y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3[⊒Ectopic p ⊒ Other (s							te ot deliv	very Day Year
ecords, P	The law requires that ite has been signed b age 2 should be deta	by	Part II. Other significant conditions Congenital Hydroc						en in Part 1.						the cause of death?
Υ	to ce	Completed	Diabetes Mellitus	s Type II							1 🗆 Y		d? [Were autoprior to co death?	opsy findings available ompletion of cause of
Division of Vital	ttending Phy death. ctor: After this y the funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigat 3 Suicide 6 Could not	be One Diese of I	jury Pay Year)	ER/Outpaties 28b. Time of Injury	M	28c. Injury Work 1 🗀 \	or: 4 □ Nu at	No For	28d. Descr	Residenc	e 6 Oth	red	al Route Number,
2	To the Hospital or Attend, within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determine 29a. Certifier 1 Certifying F	building,	etc. (Specify)	/ledge, deat	h occurred	at the tim	e, date an	d place, a	City of	the caus	State)	nner as s	stated
	To the H within 24 To the Fi complete	Medical	29b. Signature and tipe of certifier	aminer: On the basis and manner:	stated		29	c. License		th occurre	ed at the ti		Date signed		
18.00	Sta Registi		30. Name and address of person when the Swathy Furthy, 31. Date filed (Month, Day, Year) MAY 16	M.D. 613	death (Item Land trar's Signatu	over		Che	verly	r, UI	2071	55			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Phyllis Joeann Higdon May 2006 16 8:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1712 Rohrersville Road Knoxville Washington If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2√☐ F Yrs Director 217-30-5862 71 Oct 24 1934 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director MD Washington Knoxville 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 Funeral 1712 Rohrersville Road 21758 death USA Iteme : 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Co. Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed w Depertment of Heelth and Mental Hygies Important: If Item 27 is marked other to any injury or other treumatic event, In-ones. Switchboard Operator School Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George D. Rickerds Leoda Ellen Coblentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth O. Lowery, Niece 1712 Rohrersville Rd, Knoxville Md, 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brownsville Heights 5/19/2006 Brownsville, Md. 21. Singular of Fine al Service Picersus Barbara A. Williams, Owner folymernd Awas Miss Funeral Home 100 Petersville Rd, Brunswick Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HERATOCCULU **Physician** MGNTH /Medical Due to (or as a Examiner (# Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physiclen and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown Division of Vital Records, P. signed b Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2. No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete has I page 2 s autopsy performed? certificate Hacru(# MAGRASCONI 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of De ath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signat 29c, License number 29d. Date signed (Month, Day, Year) 30 Name and address of 10 31. Date filed (Month, Day, Year) State MAY 1 8 2006 Registrar

06-03472 Landon Holloway

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Year **Medical Examiner** 1223 hrs May 22, 2006 LANDON ZACHARY HOLLOWAY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYY) 9 Birthplace (State or **Funeral** Foreign Months Hours Ba Director 1 X M 01/23/2006 2 Marvland 696-03-8099 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 'n 28a-f show 1 Yes 2 X No Accomack Greenbackville with the Maryland VA Director 10e. Street and Number 10g Citizen of What Country 23a or 28 notified 3170 Aft Court 23356 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Black or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. X Never Married 2 Married Yes Widowed 4 Divorced f Yes Give Year Yes 2 X No specify. Specify. White 2 "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) b and Mental Hygiene
27 is marked other than "n
matic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles David Holloway, Jr. Be Melanie Renee Jackson ocs I and 2 sh.
ot of Health and i.
If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie R. Holloway/ Mother 3170 Aft Court, Greenbackville, VA 23356 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Important: injury or oth Salisbury Crematory 5/24/2006 Salisbury, MD Donation 5 Other Specify 22. Name and Address of Facility . Signature of Funeral Service Licenses 103 Linden Ave. Holloway Funeral Home, 2/m Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory **Physician** failure. List only one cause on each line Between Onset and /Medical Death Sudden infant death syndrome Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and rsician/Medical XX UNPENDED AMENDED item#23a,27,perME,g858,8/10/06 TT Division of Vital Records, P.O. Box 68760, 23d Date of delivery phy 23b Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 ✓ Yes No Physician: 25. Was case referred to medica 26.Place of Death (Check only one Be examiner? Other₄ DOA this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 2 1 V Yes No After 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death Certification: 1 XX Natural Yes 2 No 5 Pending Director: the Accident 28e Place of Injury - At home, farm, street, factory, office ouilding, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) vithin 24 hours a Fo the Funeral Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 23, 2006 th (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

Laron Locke MD 31. Date filed (Month, Day

2006

For State Registrar

- A	4.2	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Jay Year 3. Time of Death
Physicia		Margaret Ann Hopkins		May	16 2006 1359 1
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	7	4c. County of Death
		The Memorial Hospital	Easton		Talbot
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birti	9. Birthplace (State or Foreign
Director		214-28-3591 1 N 2 T 74 Yrs.		Sept. 2	(0,1931 Pennsylvania
p ,		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location		10d. Inside City Limits
anyla ehov	7		Preston		1 ☐Yes 2 ☑ No
8a-f	ectc				
vith th	Director	10e. Street and Number	10f. Zip Code 21655		10g. Citizen of What Country? United States
ath v	Funeral	6244 Herrington Lane		norty Vas os No	
er de item	nu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	
rs aff	by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
tura stura		15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Industry
n n	Completed	Fi viv (C viv (D 10) College (1 10) Fi)	ve kind of work done during most of work DO NOT use retired)	ang	
with piene r tha	E	G. E. D. Ho	memaker		Own Home
Hygothe other	0	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Surname)
lid be fenta rked tic ev	To B	Vernon Atlee Leight	Eugeni	a Grac	e Glenn
shou man			iling Address (Street and Number or Ru		
aith a aith a 27 is		Lloyd P. Hopkins/Spouse 624	4 Herrington La	ne, Pr	eston, MD 21655
of He item		cometen c	position (Name of rematory or other place)	Date	20c. Location - City or Town, State
Page nent e ant: if		1 ☎ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Junio	r Order Cem 05/	20/06	Preston, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at ange.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $\mathrm{F}\mathrm{r}$	amptom	Funeral Home, P.A.
827 2 9		Carrelle III. Coure	216 N. Main St., F	ederalsi	ourg, MD 21632
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory ar	rest, Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition Sep 515			1 day
/Medical		Due to (or as a consequence of):	•		3 / 5
Examiner	L	Sequentially list conditions b.	119		& WELKS
ait sit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	status Ol		2 weeks disease years
and and Il-tran	хап	that initiated events resulting in death) Last Due to (or as a consequence of):	3214astive Pag	Marin	20150130
be e sician buria	alE				
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	an/Medical	U			
n cert	M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	Cotonia scagnancy		23d. Date of delivery
deatl	Sicia		☐ Other (specify)		Month Day Year
at the by th	Physici	9 Unknown		7	
es tha		Part II. Other significant conditions contributing to death but not resulting in the	•		obacco use contribute to the cause of death?
equir ould	ted	Hypertension, Bronchier	9515	ינוו	es 2 □ No 32 Probably 4 □Unknown
as be	ple	Visystemic Lupus Erythyr	rato SIS	24a. Was autop	sy prior to completion of cause of
The page	Completed by	. 00			rmed? death? 2 No 1 Yes 2 No
cian: ertific ector.	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only o	ne)
Physi this c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time			dence 6 Other (Specify) now injury occurred
ling f	o	1 Renatural 5 ☐ Pending (Month, Day Year) Injur		280. 00301001	low injury occurred
death death stor:	Cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (5	Street and Number or Rural Route Number,
after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	oned, ladioty, oned	City or Tox	
spite ours nerei	S	29a. Certifier 12-Certifying Physicien: To the best of my knowledge, de	eath occurred at the time, date and place	and due to the	cause(s) and manner as stated.
e Ho	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time,	date and place, and due to the cause(s)
To th withir To th comp	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		band / () lon mo	039 149		5/16/06
		30. Name and address of person who completed cause of death (Item 23a) (Typ		01601	
			on St., Easton, MD	21001	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	antes.		
Regist	94				
IMH 17 Rev 1/2	2001				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

06-03146

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Darryl Christopher Jones 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ 2026 hrs May 9, 2006 **Medical Examiner** Jones Darryl C. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Clinton 6200 Hellen Lee Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) DC Director Aug.9 1975 578-94-1736 1 X M 2 F 30 Yrs Usual Residence of Decedent 10d Inside City Limits 10b. County any 10c. City, Town or Location 1 Yes 2 No or 28a-f show Maryland Prince George Clinton notified at once hours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country USA ö 6200 Hellen Lee Dr. items 23a 14. Race - American Indian, 8lack, Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or Nonust be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes ō 1 Yes 2 No specify: Specify: Black f Yes, Give Year Widowed Divorced permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiens II liten "natural", Inportant: If iten 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Baltimore, MD 21215-0036 Allegis Nursing 12 Food Services 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pamela Tunsel Jones Milton 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
871 Craigtown Road
Port Deposit, Maryland 21904 19a. Informant's Name/Relationship (Type, Print) Rodney Jones Uncle 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 5/13/2006 Alexandria Va Metropolitan Donation 5 Other Specify 22. Name and Address of Facility Adams Funeral Home 21. Signature of Fu ral Service 20605 Aquasco Rd, Aquasco MD 20608 191 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, or co Physician Between Onset and failure. List only one cause on sch line /Medical Death Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED e attending physician for use as the burial Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I this certificate has been signed by director, page 2 should be detach ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot FOUND: 1 Natural 1 Yes 2 ✓ No Pending the May 9, 2006 2022 hrs 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 | Could not be Suicide or Town, State) 6200 Hellen Lee Drive, Clinton MD determined (Specify) Home 4 Momicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe May 10, 2006 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore King MD. istrar's Signature

State

Registrar

6

	_		1 - For State Registrar	State of Ma	ryland / Depa		Health and	Mental Hy	giene 2001	5 17105
>	Physici /Medio Examir	al	Decedent's Name (First, Middle, Dorothy R. Jump Aa. Facility Name (If not institution,	give street and number)			or Location of Deat	2. Date of Dea Month May	8, 2000	5 12:30 a ^M
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	he Maryland 8a-f ehow	Director		Arundel	10c. City, Town or Lo Severna	Park			10g. Citizen of What 0	10d. Inside City Limits 1 ☐ Yes 2X No
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920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentat Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 ehow or other treumatic event. Its Medical Examinat must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2(X)No	Hispanic Origin? (S pan, Mexican, Puen Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify: W	nite, etc.
21215-0036	within 72 ho iene. rthen "natur ihe Medical"	ompleted	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) Cotlege (1-4or 5+	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire Homemak	pation o during most of wo ed)	rking	16b. Kind of Busines	
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Mary	od 2 sho lth and l 27 is ma		19a. Informant's Name/Relationsh George Lawson J			ng Address <i>(Str</i> ee St. Ives			er, City or Town, State, Park, MD 2	
Baltimore,	Department of Health a 'mportant: if item 27 is any njury or other tre		20a. Method of Disposition 12 Burial 2 Cremation 4 Donation 5 Other (Sp		20b. Place of Disponsion Commetery, creations Woodlawn	osition (Name of matory or other pla n Cemeter	1	y 11, 006	20c. Location - City of Baltimore	
Balt	Departi Imports any nj		21. Signature of Funeral Service L	All len	2: 1- 2	2. Name and Addr 3. ranco 195 Gov.	ess of Facility & Sons, I Ritchie I	P.A. Sev	verna Park verna Park	Funeral Home
	Physician /Medical Examiner	Iner	23a. Pan1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to (or as a	consequence of):	ter the mode of dy EAST C	ing, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Inset and Death
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Division of Vital	> 0 0	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig		28b. Time o	of 28c. Inju	her: 4 \(\text{Nursing F}	, , , , , , , , , , , , , , , , , , , ,	dence 6 Other (Sp now injury occurred	ecify)
Divis	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could n 4 Homicide determi		ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or I vn, State)	Rural Route Number,
	e Hospital or 24 hours afte e Funeral Dir letely filled in I	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best of examiner: On the basis of and manner stat	examination and/or in	th occurred at the to execution, in my	ime, date and place opinion, death occi	e, and due to the curred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
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-			Stuaut E.	who completed cause of de	ath (Item 23a) (Type,	Print) BRI	tgate R	d. Anv	napolis,	UND. 21401
	St Regist	ate rar	31. Date filed (Month, D	1 5 2006 Reg	r's Signature	AND				

DHMH 17 Rev 1/2001

			For State Registrar		State o	f Maryl		epartme Certifica				fental Hyg	giene No. No.	006	17	106
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	Funeral		5. Social Security N		6. Sex	7. Age (In	yrs. last birti		or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl	Year)	9. Birth	place (State	or Foreign
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			30. Name and add	iress of person	who completed cau an, M.D.,	7845	(Item 23a) (Oakwo	Type, Print) od_Road	l, ∗Su	ite 1	00,	Glen Bur	mie,	MD 21	061	
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		Registrar Decedent's Name (Firs	t Middle	Last)		Ce	rtificate	e of L	Jeani	1	2. Date of D	Reg. No	.201	16	3. Time	of Death
Physician /Medical		1. Decedent's Name (First, Middle, Last) MARGARET MYERS JONES													08:1	
Examiner	1	4a. Facility Name (If not institution, give street and number) CHESTER RIVER MANOR					4b. City, Town, or Location of Death CHESTERTOWN					4c.	4c. County of Dea			
Funeral Director		5. Social Security Numbe 218-10-8875		.Sex 1□M 2∏F	7. Age (In yrs	-	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	71 920) 9	Cou.	place (Stat ntry) MD	or Fore
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			1- For Amend Item 29d per Dr., G856, 06/12/06dhb Certificate of Death Registrar									
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death									
П	Physicia		GIADUS KOZUR 05 17 06 11:11 PM									
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
1			5767 BAY KOAD KOCK HALL MD Kent									
	Funeral Director		5. Social Security Number 16. Sex 1 M 2 K F 1 M 2 M 1 M 2 M 1 M 2 M 1 M 1 M 1 M 1 M									
	ح ع		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
	anyla shon	2	MD KENT ROCK HALL 1\(\frac{1}{2}\) Yes 2 \(\Delta\) No									
	Sa-f	Director										
	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at		10e. Street and Number 5767 BAY ROAD 10f. Zip Code USA USA									
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
9	or its	匠	1 Never Married 2 Married 1									
8	irat',	d by	3 23 VALUDWORD 4 LIDIVOICED Year or Dates:									
5	natu	lete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry									
12	within iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REPRESENTATIVE TELECOMMUNICATIONS									
p	I Hygie other	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
ylar	should be and Mental s marked o	ToE	HARRY EVANS MARY ALICE MITCHELL									
, Maryland 21215-0036	olith ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print) JULIE A. POWERS/GRANDDAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 DUTTON STREET, ASTON, PA 19014									
nore	of H of H fite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) HOCKESSIN CREMATORY 20c. Location - City or Town, State 20c. Location - City or Town, State									
3altimore,	permit. Pag Depertment Important: i eny injury o	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUENRAL HOME 130 SPEER ROAD, CHESTERTOWN, MD 21620									
	2 □ E ● Q											
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
			Immediate Cause (Final disease of condition resulting in death)									
	Examiner		Due to (or as a consequence of):									
	ם ד	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury									
60, be executed sician and burial-transit		Examin	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):									
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687	physics to the the the the the the the the the the	dic	d									
O. Box (The law requires that the death certificate be executed to hes been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes \ 2 \] No 9 \[Unknown \] 23c. If yes, outcome of pregnancy 1 \[Live birth \ 2 \] Fetal death 4 \[Yegnant at time of death 9 \] Unknown 2 \[Unknown \] 23d. Date of delivery Month Day Year									
P.0	that the		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									
rds	w requires been sign should be	ted by	METASTATIC OVARIAN CAMPER 1-Yes 2100 3-Probably 4-Unknown									
of Vital Records,	The law resete hes be	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of performed death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No									
ita	dertifice certifice rector, p	Be	25. Was case referred medical examiner?									
>	\$ <u>∞</u> 5	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)									
			27. Many r of Death 28a. Date of Injury 1 Natural 5 Pending 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?									
sio	De c	cati	2 Accident investigation M 1 Yes 2 No									
Division	lai or Attendestis after death	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)									
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by ti	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the To the comp	Ň	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)									
			D 76054 May 17, 2006									
2) m.s.		20 Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICK Shanahan 120 Speci RoBidy B Chestertown HD 2162e)									
	Sta Registr		31. Date filed (Month, Day, Year) 32. Register's Signature									

			1 - For State Registrar	State of	Marylar				ealth a Death	and M	ental Hygi	ene g. No.	2006	5 17	109
			1. Decedent's Name (First, Middle, La	st)							2. Date of Death Month	Day	Voor	3. Time of	Death
	Physici		Paul L	Knot	t						May 1		2006	3:00	A M
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of			4c. C	ounty of Death)	
	LXann	101	201 Garner Ave				Wa 1	dor	f			Ch	arles		
	Europal		5. Social Security Number 6. S	ex 7	. Age (In yrs.	. last birthday)	If Unde	r 1 Year	If Under		8. Date of Birth			place (State o	or Foreign
	Funeral Director			X □M 2□F	48	Yrs.	Months	Days	Hours	Min.	(Month, Day, Feb. 17	Year) . 1 9	58Mars	place (State of intry)	
			Usual Residence of Decedent				1				100.17	, , ,	Joriar	Tuna	-
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside C	ity Limits
	Mary	ō	Maryland Char	lee	W = -	ldorf								1 🔀 Yes	2 🗆 No
	1he 288	Director	10e. Street and Number	165	wa.	LUCII	10f Zir	Code			10	a. Citiza	en of What Cou	intry?	
	within 72 hours atter death with the Maryland ane. than "natural", or itema 23a or 28a-f show the Madical Examinar must be notified at	ā												, .	
	ath a	Funerai	201 Garner Ave		ant Constinut	16 112		602		-:-2 (6		USA	Bass Amer	inga Indian	
	ar de	un	11. Marital Status	12. Was Deced Armed Ford	es?	J.S. 13.	was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexican	gin / (Spec i, Puerto F	cify Yes or No- lican, etc.)	14	 Race - Amer Black, White 		
36	or i	by F	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes	2X No	Specity:			9	Specify: Bla	ale	
21215-0036	ura!	d D	3 Widowed 4 Divorced	Year or Dat	es:										
Ŋ	72 net	Completed	15. Decedent's E- (Specify only highest gra			16a. Dece	kind of wo	al Occupa ork done o	ation fu <i>ri</i> ng mosi)	t of workin	g 1	6b. Kine	d of Business/la	ndustry	
7	ithin	du	Elementary/Secondary (0-12)	College (1-4	tor 5+)			- 220	,			٠.	-		
	ygiel ygiel t, t	S	12			Ope	rato	r					way Pa	iving	
pu	d oth	Be	17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle, M	aiden S	umame)		
<u> </u>	Men	ဥ	Wade J. Knott						Dore	othy	E. Ba	ker			
Maryland	sho and amm		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Addres	s (Street a	nd Numbe	r or Rural	Route Number,	City or	Town, State, Zi	p Code)	
	alth alth		Tomika Knott/D	aughter		4310	Mid	dlet	cown	Rd,	Pomfre	t Mi	D 2067	5	
ē,	S 1 8		20a. Method of Disposition		20b.	Place of Dispo	sition (Na.	me of					ation - City or T		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itema 23s or 28s-f show miportant: If Itam 27 is marked other than "natural", or itema 23s or 28s-f show my Injury or other traumatic avent, the Modical Experiment per routiled at DDCs.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		st.	. Mary				5/19	/2006	Naw	nort	MD	
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			23a. Part1. Enter the disease, or com	aliant and that and	19						Aguas		MDZU	Approximat	
н			shock, or heart failure. List only	one cause on ear	chiline.	1				Α				Interval Bet Onset and	ween
1	Physician		Immediate Cause (Final disease or condition	a 9/	heros	dustie	Ca	rdis	7/22	cular	dise	asi			
	/Medical Examiner		resulting in death)	Due to (o	as a come	quence of):									
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	The law requires that the death certific the has been signed by the attending froaga 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23	d. Date of deliv	/ALL	
Вох	atter for u	Siar	in the past 12 months?		th 2 ☐ Fet nt at time of		Ectopic p Other (s						Month	•	Year
Ö	the d	ysic	1 Yes 2 No 9 Unknown	9□ Unknow		Godin 3	Other (s)	Journy)							
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æ	The I	E									perform	ed2 No	death?		103 0 01
ta		O	25. Was case referred to medical						26 Place	of Death	1 Yes 2 (Check only one		1 1 103	2 110	
Vital	Physician: this certific ral director,	100	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2] ER/Outpatier	nt 3□ D	Othe			ne 5 Resider		Dothar (Care	4.3	
ō	Phys ratidis	<u>۲</u>	27. Manner of Death	28a. Date of		28b. Time o		28c. Injury			8d. Describe how			7y)	
n	ath. r: After ie funer	0	1-Natural 5 Pending	(Month,	Day Year)	Injury	м	Work	:? ∕es 2 ∐ f			,,			
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<u>></u>	or A after Direct in by	E	4 ☐ Homicide determined	building	g, etc. (Spec	ify)	eet, ractor	y, onice		-	City or Town,	State)	IVUSIDES OF HUS	ai rioute ivum	Der,
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: Atter completaly filled in by the funer	ပိ													
	Hospital 24 hours a Funeral italy filled	Medicai	29a. Certifier 1 ☐ Certifying P! (Check only 2 ☐ Medical Exel	niner: On the bas	is of examin	owledge, death	h occurred	at the tim	e, date and	d place, a	nd due to the car d at the time, da	use(s) a	nd manner as	stated, to the cause/s)
	the Prin 24	ed	one)	and manne	er stated.									``	,
	To the within 2 To the comple	Σ	29b. Signature and title of certified	114			29	c. License	number		29	d. Date	signed (Month,	Day, Year)	
		1		AHTan	1_) 22	574		Mo	5	115/0	6	
C			30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type.	Print)				. , ,		1.	-	
1	BZ							ant-	m C	. 4 4 -	Waldor	- f	Marul	and o	1604
41	W	ate	R. Timothy Pace 31. Date filed (Month, Day) 1990 1	32. Rec	gist r's Sian	ature	116 C	GIIDE	T DI	ii ce	maraoi		rat y 1	and Zi	1004
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		1 - State Registrar				Ce	rtifica	te of	Death			Reg. No.	. 0 0	0		
Physic	ian	Decedent's Name (First, Min									Date of De Month	Day		Year	3. Time of	
/Med	ical	RAMONA JUNE			nharl		4b. City	Town	r Location of		May 15		06 County o	of Death	5:1.	5 p [№]
Exami	ner	4a. Facility Name (If not institu				.1				Deam					•	
Funera	7	Washington A 5. Social Security Number	6. Sex			yrs. last birthday	If Unde	oma r 1 Year	If Under 2	24 Hrs. {	8. Date of Bir (Month, Da	th	ontg		place (State ontry)	or Foreig
Director		579-43-5909	1 🗆	M 2(X) F		77 Yrs.	Months	Days	Hours	MIII.	June 10	0, 19			isy1vai	
5-UUSO 72 hours after death with the Maryland natural', or Items 23a or 28a-f show alters Framing must be notitied at		10a. State 10b. Cou	nty		10c	. City, Town or L	ocation							1	10d. Inside C	-
e Mar	ctor	Maryland Prin	ce Ge	orge's	Н	lyattsvi	11e								1 X Yes	2 🗆 No
or 28	Dire	10e. Street and Number					10f. Zi	p Code				10g. Citi:	zen of W	hat Cour	ntry?	
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Hygie ther ther ther	S	12 17. Father's Name (First, Midd	le. Last)			Home	emake	r	18. Mother	r's Name	(First, Middle		Home			
Maryland nd 2 should be file lith and Mental Hy 27 le marked oth	To Be	Richard W. G									Bechte					
DEBILITION Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show any injury or other treumatic event, the Macital Examinal must be notified at once.	1	19a. Informant's Name/Relation		oe, Print)		19b. Mail	ing Addres	s (Street			Route Numb		r Town, S	state, Zip	Code)	
Mind 2 and 2 alth a alth a 127 le		William E. Kr	oppe.	1 - Spe	ouse	6124	421	nd A	enue,	Hyat	ttsvil,	le.	iary.	Land	20781	
of He of He		20a. Method of Disposition 1 ☐ Burial / 2 ☒ Crematic	n 3 □B	emoval from		Db. Place of Disp cemetery, cre	osition (Na	me of		Da	ite	20c. Lo	cation - C	ity or To	own, State	
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Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		21. Signature of Funeral Serv	ce License	94/	_						ch's F					
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	þ	Part II. Other significant cond	litions con	tributing to de	ath but not	t resulting in the	underlying	cause giv	ren in Part I.			obacco u Yes 2			he cause of coably 4 💥	
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bly is a ster dea a st	Certification:	3 Suicide 6 □ Coi	ild not be ermined	28e. Place buildi	of Injury ng, etc. (Sp	At home, farm, s	reet, facto	ry, office		28	Bf. Location (City or To			r or Rura	al Route Num	nber,
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical			ner: On the ba		r knowledge, dea mination and/or i						date and	place, ar	nd due to	the cause(s	s)
To the comp	Σ	29b. Signature and title of cer	flief /	A)	0 1	0	29		e number			29d. Date	ə signəd	(Month,	Day, Year)	
		• /(1.4	70	4)	8	D4	5471			May	16,	200	16	
161		30. Name and address of pers	1/													-
		Yeheyis Negus 31. Date filed (Month, Day, Ye		MD Wa	shing	ton Adv	entis	t Ho	spital	, Ta	koma P	ark,	Mar	ylan	.d	
S Regis	tate trar	MAY 1 8 2		Been		ignature	E)									

06-03200

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jong Sung Kim 1- For State Certificate of Death Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ 0756 hrs Medical Examiner May 12, 2006 JONG SUNG KTM

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 212 23 8544 Months Davs Hours Min. Director Country) 1X M 2 29 1961 45 JAN KOREA Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits MONTGOMERY GERMANTOWN MD Yes 2 No 23a or 28a-f show notified at once, death with the Maryland 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 13906 20874 ā BRIWICK ST. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S Armed Forces 1 Never Married 2 X Married 2 X No Yes 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify ASIAN hours after marked other than "natural", c event, the Medical Examiner <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 4 PROPRIETOR permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) YOL BYUNG KIM YONG SUL KIM Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n r traumatic JAMES KIM /BROTHER 19832 BETHPAGE CT ASHBURN VA 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 5/17/06 GATE OF HEAVEN SILVER SPRING MD Donation 5 Other Specify 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV ice Licensee Signature of F DR UPPER MARLBORO Approximate Interval Between Onset and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line /Medical Death a. Acute Coronary Artery Thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate ✓ Yes 2 ✓ Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other DOA Inpatient 2 V ER/Outpatient 3 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural 1 Yes 2 No 5 Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) ionature and title of certifie May 13, 2006 O.C.M.E. nd address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

Day Year) 2006 State Registrar

Funeral Director

	1 - State Registrar		(ertifica	ite of L	Death		2 Date of F	Reg. N	0.		0 Time (D)
an	Decedent's Name (First, Middle, Last)							2. Date of E Month		ay Ye	ar	3. Time of Dea
al	Eva Krebs			41.03	-		6 D 45	May	11	2006		3:15 A
er	4a. Fecility Name (If not institution, give s		- 1			Location of	n Death			c. County of D		
	Shady Grove Advent 5. Social Security Number 6. Sex		a⊥ ryrs. last birtho		Rockv: ler 1 Year		24 Hrs.	8. Date of E		Montgo		
			34 Yrs	Month	s Days	Hours	Min.	(Month, L	Day, Year			ice (State or Fo
ł	Usual Residence of Decedent							June	11,1	921	erm	any
	10a. State 10b. County	10	c. City, Town o	r Location							10	d. Inside City Li
cto	MD Montgom	ery		Rockvi	ille							1 ☐ Yes 2X
Director	10e. Street and Number			10f. Z	Zip Code				10g. C	itizen of What	Countr	y?
	9701 Medical Ce				2085					nited		
Funerai		12. Was Decedent Ever Armed Forces?	r in U.S.	 Was Dec If Yes, sp 	edent of Hi ecify Cuba	ispanic Orig In, Mexican,	gin? (Spec i, Puerto P	cify Yes or Nican, etc.)	No-	14. Race - A Black, V		
by F	1 Married 2 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:				Specify:	Wh	ite
	15. Decedent's Educ		16a D	ecedent's Us	ual Occup	ation			16b I	Kind of Busine		
Completed	(Specify only highest grade	completed)	(0	ive kind of v	vork done d	during most	of workin	g	100.1	IVIII OI DUSIIIE	333/11/00	stry
E	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales	Clerk	c				Groces	rw	
BeC	17. Father's Name (First, Middle, Last)						r's Name	(First, Midd	le, Maide	n Sumame)	<u> </u>	
To B	Wilhelm Krebs					Ger	rtrud	e Lau	tens	chlaege	r	
-	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. M	ailing Addre	ss (Street a					or Town, Stat		Code)
	Hildegard MacLean	/ Friend	1114	07 T.o.c	ustda	le Te	rrac	e. Con	rmant	town, N	m 2	0.976
	20a. Method of Disposition	2	Ob. Place of D	sposition (No	lame of		Da	ite	20c. l	ocation - City	or Tow	n, State
	1 ∑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		All Sou			¹ M	fay 1	3 006		and the second second	20000 2	N. F. S.
	21. Signature of Funeral Service License		500			ss of Facility	-	-		rmantow al Home		
	TRACY ASTA	ever		Deer	Park	Drive	, Ga	ithers	sburg	g, MD 2	087	7
	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	death. Do not								1	Approximate nterval Between
	Immediate Cause (Final	MYOCA	PNIAI	INFR	WCT	ION						Onset and Deat
	disease or condition resulting in death)	Due to (or as a co			, , , ,						-	1 MINU
	Conventiable list conditions	(DNGE	STIVE	HEAR	TFI	AILUK	2E					Day
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	insequence of)									
Examiner	Cause (Disease or injury that initiated events											
	resulting in death) Last	Due to (or as a co	insequence of):									
lical											-	
cian/Medi	IF FEMALE:	o- 16 iii - 16 iii										
ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death	3 □Ectopic						23d. Date of Month	,	ay Year
hysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	e of death	5 Other (specify)							-,
Δ.	Part II. Other significant conditions con	tributing to death but no	ot resulting in th	e underlying	I Callea dive	an in Part I		23e Did	Itobacco	use contribut	e to the	cause of death
d by	•		-		, g							oly 4120Unkn
etec												
ompieted									is an opsy formed?		to comp	y findings avail detion of cause
O								1□ Yes			es 2	□ No
Be	25. Was case referred to medical examiner?	ospital:			Othe	00		Check only				
5	1 ☐ Yes 2 X No 27. Manner of Death	1 X Inpatient 28a. Date of friury	2 ER/Outpa		JUA	4 Nur				6 Other (S	pecity)	
ţ	1 Statural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Inju		28c. Injury Work	k? Yes 2 □ N		od. Dogoribe	3 110 W 1114C	ary cocarred		
fica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm					3f. Location	(Street a	nd Number or	Rural F	Route Number,
Certification:	4 Homicide determined	building, etc. (S	pecify)	, 0.11001, 12011	sry, omoo			City or To	own, Stat	(e)	7101077	rosio resinizor,
	29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowledge, d	eath occurre	ed at the tim	ne, date and	d place, ar	nd due to the	e cause(s	s) and manner	as stat	ed.
edicai	(Check only 2 Medical Examinations)	ner: On the basis of exa and manner stated.	imination and/o	r investigatio	on, in my op	oinion, death	h occurred	d at the time	e, date an	d place, and	due to th	ne cause(s)
Me	29b. Signature and title of certifier	p		2	9c. License	number			29d. Da	ate signed (Me	onth, Da	iy, Year)
	PMaduar				DUO	6312	9		M	144 11.	20	06
	30. Name and address of person who co		(Item 23a) (Tv	pe. Print)	-		1					
	POWLIMI HADKA	0	1 Seven		s Roa	d. Roo	ckvi1	le. M	D 20	854		
	TOVORING MADEN	, , <u>1</u> 20		Josefe		u, KU	~ V ^ T T	لاد وعد	w 40	JJ 1		

Physician /Medica Examine Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23e or 28e-1 show eny injury or other treumatic event, the Medical Examinal must be published at ODGs.

L-ANNING, RICHARD Baltimore, Maryland 21215-0036

De executed Sicien and Surial-transit aburial-transit cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a No M Due to (or a / M Due to (or a
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Functei Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director: page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	25. Was case dent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions cont CHRON C SF MANUTURE 25. Was case referred to medical examiner? 1 Yes 2 No	Ospital: Natripa 28a. Date of I (Month, E
To the Hosp within 24 hou to the Fune Completely fill	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exeminone) 29b. Signature and title of certifier	er: On the basis and manner
State Registrar	30. Name and address of person who con STANCHYPTO 31. Date filed (Month, Day, Year) MAY 1 2	32. Regis

	<mark>rpe or Print in Black In</mark> State of Maryland / Depa		-	
1 - For State Registrar	Ce	rtificate of Death	Reg. No	2000 1/110
1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	y Year
Richard Earl Lanni	ng		May 10,	2006 1:50 p ^M
4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Location of Death		. County of Death
Greater Baltimore		Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	11timore 9. Birthplace (State or Foreign
5. Social Security Number 6. Sex 1 (3)	7. Age (In yrs. last birthday) M 2□ F	Months Days Hours Min.	June 16, 1	Country)
Usuel Residence of Decedent	68 Yrs.		Julie 10, 1	.93/ New York
10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
MD Carroll	Woodbine	·		1 ☐ Yes 2 No
10e. Street and Number		10f. Zip Code	10g. Ci	tizen of What Country?
6371 Woodbine Rd.		21797		ted States
TI, Maria States	Armed Forces?	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puert	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
1 Never Married 2 Narried 3 Widowed 4 Divorced	1 Tyes 2 No 1959 If Yes, Give Year or Dates: 196/	1 ☐ Yes 🏋 No Specify:		Specify: White
15. Decedent's Educa	1704	edent's Usual Occupation	16b. K	(ind of Business/Industry
(Specify only highest grade	completed) (Give	a kind of work done during most of wor DO NOT use retired)	king	
Elementary/Secondary (0·12) 12th	College (1-4or 5+) Truck	Driver	Pott	s andCallahan
17. Father's Name (First, Middle, Last)			ne (First, Middle, Maider	Surname)
Charles Lanning		Luella	Ihomas	
19a. Informant's Name/Relationship (Typ		ing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
Maureen B. Lanning		Woodbine Rd. Woo		
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ren Cemetery 5/16/		ocation - City or Town, State n Burnie, MD
21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not en	22. Name and Address of Facility Surrier-Queen Fune 212 W. Old Libert hter the mode of dying, such as cardiad	v rd. Winti	d Crematory, P.A. eld, MD 21784 Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	MY FAILURIE NS LYMPHOMA NESSON 29 Lyn LL CARRINSMA	nphond	10ggs 3 wh MONTH
IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Dther significant conditions conf	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
CHRONC /SE	DOMONAS INFER	TION, WOUND	1 🗆 Yes 2	No 3 Probably 4 Unknow
SPOTU	27		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
MARNUMITH			autopsy performed? 1 ☐ Yes 2 ☑ N	death?
25. Was case referred to medical	,,,	26. Place of De	ath (Check only one)	
examiner?	ospital: 1 Impatient 2 ER/Outpatie	Othors	lome 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how inju	ury occurred
2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street a City or Town, Stat	ind Number or Rural Route Number, te)
(Check only 2 Medical Exemin	icien: To the best of my knowledge, deaer: On the basis of examination and/or i	ath occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cause(s) and manner as stated. Individual of the cause (s)
one)	and manner stated.	29c. License number		ate signed (Month, Day, Year)
29b. Signature and title of certifier Number Number	neder an	D28133		5/11/26
30. Name and address of person who con	mpleted cause of death (Item 23a) (Type	Print) John Saund BATTIVIONE MIT	lers, M.D.	
31. Date filed (Month, Day, Year) MAY 1 2	32. Registrar's Signature	doct.		

Amended Item 1 per Physician 05/18/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Lambert Keziah Month 05 **Physician** Keziak 2006 ambert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakcrest Retirement Community Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F 86 Director 216-12-6278 05-02-1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Iteme 23a or 28a-f ehow eny Injury or other treumatic event, the Medical Exeminal must be notified at 10c. City, Town or Location 10a, State 10b. County MD Baltimore Parkville Direct 10e. Street and Number 10g, Citizen of What Country? 10f. Zin Code Apt 4107 8820 Walther Blvd 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 # No Specify Specify: White 2 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MD State Highway Elementary/Secondary (0-12) College (1-4or 5+) 11 Administration Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Brathuhn Bertha S. Myers 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Scarlet-Stein 13423 Blenfield Rd. Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 13 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Pleasant Grove 4 ☐ Donation 5 ☐ Other (Specify) 2006 Reisterstown, MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Eugeral Service Licensee PDCe Ki M00723 934 South Main Street Hampstead, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of)

3. Time of Death

Birthplace (State or Foreign Country)

21074

29d. Date signed (Month, Day, Year)

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2√ No

MD

11:42a [™]

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

use as the burial-transit The law requires that the death certificate be executed the ettending physician cate has been signed by the ette, page 2 should be detached for

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

29b. Signature and title of certifier

ours after death.
neral Director: A
filled in by the fu within 24 hours a

this certificate

Division of Vital Records, P.O. Box 68760,

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II Other significant conditions ASTAMA	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an 24b. Were autopsy findings available of the cause of death?
25. Was case referred to medical		autopsy prior to completion of cause or death? 1 □ Yes 2 No 1 □ Yes 2 No
examiner? 1 Yes 2 No	26. Place of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Hom	Check only one te 5 Residence 6 □Other (Specify)
27. Manner of Death 1	28a. Date of Injury 28b. Time of (Month, Day Year) 28b. Time of Work? 28c. Injury at Work?	8d. Describe how injury occurred
3 Suicide 6 Could not determine		Bf. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: Tu the best of my knowledge, death occurred at the time, date and class a semination and/or investigation, in my opinion, death occurred	

State Registrar

(Type, Print) D58646 MAY 12, 2006 8800 Walther Boulevard Parkville, MD Monias 31. Date filed (Month, Day, Year) MAY 1 32. Resistrar's Signature

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WJL 20

			1 - For State Registrar	State of M	larylan		artmen			and M		Reg. No	<u> </u>	5 1	17115
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Month	Death Da	y Ye		3. Time of Death
8/	/Medi		Bearneas Mae	e Lowe							May	11,	2006	10	0:55 p ^м
	Examir	ner	4a. Facility Name (If not institution,	give street and number	r)		-		Location of			40	. County of D		
		igo-	Continuum Care		lle				ville				Carr	oll	
	Funeral Director		5. Social Security Number 217–24–3120 Usual Residence of Decedent	5. Sex 7. A 1 □ M 2 🙀 F	ge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Sep 1	Birth Bay, Ygar 19	20 -	Birthplace Co <i>untry)</i> [ary]	e (State or Foreign and
	Aaryland f show	or	10a. State 10b. County Maryland Carr	oll	10c. Cit	y, Town or Lo	cation	S	ykesv	ille					Inside City Limits
	vith the h	Funeral Director	10e. Street and Number				10f. Zip	Code	21	784		10g. Ci	tizen of What	Country?	
	s 23s	ra	7309 Second Aven										USA		-
920	72 hours after death with the Maryland Insturel, or items 23s or 28s-f show Licel Eventher met for Indified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Marrie 32 Widowed 4 □ Divorced	12. Was Deceden Armed Forces d 1 Tyes 2 If Yes, Give Year or Dates	?] No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - A Black, W Specify:	merican I hite, etc. whi	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show say injury or other treumstic event, the Medical Event har must be profitted at another.	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 4	Education grade completed) College (1-4or	5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done d	uring most	t of worki	ing		ind of Busine		ry
land 2	uld be filed Mental Hygi irked other tic event, I	To Be Co	17. Father's Name (First, Middle, La Vernon W. Myer			1					(First, Midd dela I				
Mary	ind 2 sho alth and N 27 is me	ľ	19a. Informant's Name/Relationshi Bonnie E. Little			19b. Mailin	S. He	(Street a	nd Numbe	r or Rura !r.#B	Route Num	ner, City o	AK 99	в, <i>Zip C</i> od 645	de)
Baltimore,	Pages 1 a lent of He nt: if itam ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	B □Removal from State	. 0	lace of Dispo emetery, cren th Car:	natory or ot	her place		05/	13 1006		ocation - City		
Balti	permit. Departm Imports eny inju	1	21. Six ature of Funeral Service Li	censee M	01191	22	. Name and	d Addres	s of Facility	y My	ers-Di	urbor	aw Fun r, MD	eral	Home
	Physician	1	23a. Part . Enter the disease, or c shock, or heart failure. List or hymediate Cause (Final	omplications that cause only one cause on each	od the death	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory	arrest,		Inte	proximate erval Between set and Death
T.	/Medical Examiner		disease or condition resulting in death)	Due to (or a	s a consequ	uence of):	^								ears
	d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a	s a consequ	uence of):									
8760,	icate be executed physician and s the burial-transit	ical Exa	resulting in death) Last	c. Due to (or a.	s a consequ	uence of):									
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P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date of o Month	delivery Day	Year
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≡	clan: ertificación	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check only	one)			
5	hysi this c	P.	1 □ Yes 2 No			ER/Outpatient			4 Layur	sing Hon	ne 5□Re	sidence (6 □Other (S _j	pecify)	
Division of Vital	Attending Physician: The I sr death. sector: After this certificate haby the funeral director, page	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no		ury ay Yea <i>r)</i>	28b. Time of Injury	M 28	Sc. Injury Work: 1 TY	at ? es 2 □ N		8d. Describe	how injur	y occurred		
N N	ital or At irs after d ral Direct	O	4 Homicide determin	ed 286. Place of In building, e	tc. (Specify	') 					City or T	own, State			
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical	one)	Physicien: To the best reminer: On the basis and manner s	of examinat	wledge, death ion and/or inv	estigation,	in my opi	nion, death	d place, a h occurre	ind due to the	, date and	place, and d	ue to the	cause(s)
1	To the within to the complex	4	29b. Signature and title of certifier	a as				License	258	5 (3	7	5	e signed (Mo	nth, Day,	Year)
	3		30. Name and address of person who will bir King	295	Ston	e A	erint)	- 3:	27	W	ostonik	iste	MO	211	5-7
	Sta Registr		31. Date filed (Month, Day, Year) MAY 15 2	37 Regist	rar's Signat	ure do	of a								

			1 - For State Registrar	State of M	aryland /	•	artment tificate			and M		jiene	06	17116
j	Physici /Medic		1. Decedent's Name (First, Middle, Last ERNEST H. LEAP,								2. Date of Dea Month MAY		006	3. Time of Death $10:20 \ A\!M$
	Examin		4a. Facility Name (If not institution, give CHESTER RIVER HC				, ,		Location o			4c. County	of Death	
	Funeral Director		5. Social Security Number 215-20-1472 6. Se	x 7. Ag M 2□F	ge (In yrs. last b 77	Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day JULY I	, Year) 1928	9. Birthp Cour	lace (State or Foreign ltry)
	Maryland f show led al	'n	Usual Residence of Decedent		10c. City, To		cation CTON						1	0d. Inside City Limits
	with the 3a or 28a-	Funeral Director	10e. Street and Number 12203 AZALEA COU	 RT			10f. Zip	Code 216	78			10g. Citizen of USA	What Cour	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel; or items 23a or 28a-f show simportent: If item 27 is marked other then "naturel; or items 23a or 28a-f show apply injury or other treumatic event, the Medical Examinal must be notified at once.	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces: 1 M Yes 2 ☐ If Yes, Give Year or Dates:	?		Was Deced f Yes, spec		spanic Orion, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, y: WHI	etc.
21215-0036	d within 72 ho giene. sr then "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or		(Give life. L	dent's Usua kind of wor DO NOT us ICATOR	k done di e retired)	uring most	of work	ing	16b. Kind of B	usiness/Ind	·
Maryland	2 should be filed and Mental Hygie is marked other eumatic event,	To Be C	17. Father's Name (First, Middle, Last) ERNEST H. LEAP, S	₹.							e (First, Middle, E WRIGH		ne)	
	and 2 sho ealth and h n 27 is ma		19a. Informant's Name/Relationship (7) DOROTHY LEAP/WIFE	ype, Print)	19		-				WORTON,			Code)
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Balt	permit. Pag Department Importent: eny injury o	ļ	21. Signature of Funeral Service Licens	lerbein)		F		S, E EER	ELFE ROAD	NBEI CH			UNERA 21620	L HOME, P.A
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c 68760,	artificate be executed ing physician and e as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	d	a consequenc	e of):						75-100		MIN A THE
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Ś	quires that n signed by uld be deta		Part II. Other significant conditions of	mana		-						bacco use con es 2 \(\subseteq No		ne cause of death?
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DIX	afte Dir		4 Homicide determined	286. Place of in	tc. (Specify)				o date an		City or Tow	n, State)		I Route Number,
	To the Hospitel within 24 hours: To the Funerel completely filled	Medical	(Check only one) 29b. Signature and title of certifier		of examination		vestigation,		inion, deal		ed at the time, d		and due to	the cause(s)
(1 grate	-	> ////Cllim	, MD.	death (Itom 30-	a\ /Tu	Print	1)21	313			5/11/0	6	
	ms		30. Name and address of person who of KIN K. WUN, 31. Date filed (Month, Day, Year)	11111111111	Hungler ran Signature	n Ac	(2.) C	ches	tertow	n,	mp 2	1620		
	Sta Regist			6 2006 ▶	Bons	A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Ttem 10d per fn 8856 6-1-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 0728 AM Nathan Leonard 8 2006 May 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3 Steele Avenue Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2□F Yrs 153-01-5307 85 Aug. 29,1920 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD 1 XYes 2 ☐ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Steele Avenue 21401 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 DYes 2 No WW II 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Podiatrist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Lipschultz Anna Palski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Edith Earle Leonard 3 Steele Ave. Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kneseth Israel Cem. 5/9/2006 Annapolis, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401 21. Signature of Funeral Service Licenses alsul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respension disease or condition resulting in death) Due to (or as a consequence of): HERATESE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2)XNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ale 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifia

/Medical Examiner sicien and burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. ettending physi ned by the e s been signer should be d s certificete has l lirector, page 2 s this After thi Director: / within 24 hours after or To the Funeral Direct completely filled in by

Physician

/Medical

Examiner

Funeral

Director

"natural", or iteme 23s or 28s-1 show

Director

Completed by Funeral

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Medical Certification:

(Chack only one)

29b. Signature and title of certifier

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: if item 27 is marked other then "accept hipty or other treuments."

Physician

State Registrar

yenue 31. Date filed (Month, Day, Year) AY 1 5 2006

PRIMA

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year) 05/08/2006

Michael Riebman

				State of Maryland	/ Depar	tment of H		•	ygiene	e contraction	1-7110
				Stata Registrar	Cert	ificate of	Death	2. Date of	Reg. No	200b	1/1/8
		Physici	an	1. Decedent's Name (First, Middle, Last)				Month MAY	Day 14	2006	3. Time of Death 4:15P.M.
		/Medic Examir		VIRGINIA ELIZABETH LUM 4a. Fecility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death			. County of Death	
		Exami		REEDERS MEMORIAL HOME		BOO	ONSBORO			WASHI	NGTON
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of 1 (Month,	3irth Day, Year)	9. Birth Cou	hplace (State or Foreign untry)
hi		Director		220-16-0129 99 Usual Residence of Decedent	113.			MARCH	15,1	907 WES	I VIRGINIA
N		nyland how		10a. State 10b. County 10c. City, T	Town or Loca	ation					10d. Inside City Limits
A		within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show tra M. cleal Excriting to ust be notified at	Director	MARYLAND WASHINGTON			BOONSBOR	0	T		1 X Yes 2 No
-		with the		10e. Street and Number		10f. Zip Code	01710		10g. Cit	izen of What Co	
411		ns 23	Funeral	141 SOUTH MAIN STREET 11. Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of H	21713 Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or	No-	U.S.	rican Indian,
3	9	or ite	Fur	Armed Forces? 1 ☐ Never Married 2 ☐ Married If Yes, Give		Yes, specify Cuba □ Yes 2☑ No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	, etc.
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LM,		buld be filed with Mental Hygiene arked other tha atic event, the	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	,		Sumame)	
7	yla	2 should be filed and Mental Hygi Is marked other eumatic event,	7	JAMES EDWARD HAMMERSLA	405 14-18	444	BESSIE J			T 0	
	Maryland	nd 2 st alth and 27 Is n		19a. Informant's Name/Relationship (Type, Print) RICHARD L. LUM/SON		AKIN AVI	and Number or Ru	nsboro Nsboro	-		ip Code) 21713
W		s 1 a if Hei item othe		20a. Method of Disposition 20b. Plac	e of Disposit	tion (Name of atory or other place		Date	-	ocation - City or T	
AME	E C	Pages nent of ant: If it	١.,	1 M Burial 2 Uremation 3 Hemoval from State		CEMETERY		7/2006	BOOT	NSPORO.	MARYLAND
A	Baltimore	permit. Page Department o Importent: If any injury or once.		21. Signature of Fureral Savi Licentee Paul M. Dea	22.1	Name and Addre	ss of Facility	7606	old Na	ational	Pike
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		Physician /Medical		disease or condition resulting in death) a. Les of Yayon Due to (or as a consequent	YY nce of):	Janu	me				24 hrs.
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		sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Union lining Cause (Disease or injury	nce of):						
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		leath certificat attending phy ifor use as th		IF FEMALE:							
	Вох 68	ath ce ttendii or use	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	eath 3□E	ctopic pregnancy	/		:	23d. Date of deliv Month	very Day Year
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	rds	equires en sign ould be		Senility				10	Yes 2	Z No 3□Pro	bably 4 Unknown
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	Division of Vital Records,	: The cate h	Con	Al Themer's Dame	nhe	•		per 1 ☐ Yes	rformed?	death?	2 No
	Vita	Physicien: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 ER	2/0	oth Oth	26. Place of Deat				
	of	ing Phys n. After this funeral di	-	27. Manner of Death 28a. Date of Injury 28	Bb. Time of	28c. Injur Wor	y at	28d. Describ		6 Other (Speci y occurred	<i>(y)</i>
	ion	anding sath. or: Aft he fun	atio	2 Accident investigation	Injury		Yes 2 □No				
	i≤i	or Atti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location City or T	(Street and own, State)	d Number or Rur)	ral Route Number,
		purs a pours a lerel [29a. Certifier 12 Certifying Physician: To the best of my knowle		occurred at the tin	ne date and place	and due to th	e cause(s)	and manner as	etated
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		Vithir To th	M	29b. Signature and title of centier		29c. Licens			29d. Dat	e signed (Month,	Day, Year)
						DL	14996		Mai	4 15,	2006
	7 2L	1-2		30. Name and address of person who completed cause of death (Item 23			RO MARVI	AND 21	713	301-43	2-8470
`		Sta	ite	DR. ZAFAR MALIK, 20311 LAPPANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Date filed (Month, Day, Year)	0 /		IIANIL	-1440 CI	, 10	001-40	_ 01/0
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	Physici /Medi Examir	al	Leroy Elbert 4a. Facility Name (If not institution, given	Logue re street and number)		4b. City, Town,	, or Location of	MAY		2006 ounty of Death	2:30 PM
			Reeders Memori				onsbor		Wa	shingto	on County
	Funeral Director			Sex 7. Age (In	yrs. last birthday)	If Under 1 Yea Months Day		Min. (Month, Da	th	9. Birthp Coun	lace (State or Foreign try) Cyland
	laryland show		10a. State 10b. County	100	c. City, Town or Lo	ocation				1	0d. Inside City Limits
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	with the Mi a or 28a-1 Lbs notifie	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Coun	itry?
	€ 23	ai D	17399 Oak Ridge	Drive			21740			U.S.A.	
	ter death Itama 23	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	_	Was Decedent of	Hispanic Orig	in? (Specify Yes or No Puerto Rican, etc.)	- 14.	Race - Americ Black, White,	
9036	a o E	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Y☐Yes 2☐No	3-7-3 I	1□Yes 2XN		. 25,15 1115211, 515.)		pecity: Whi	
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687	phys phys the	Physician/Medical	•	d							
×	w requires that the death certifica been signed by the attending pt should be detached for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro	egnancy						
Вох	atter d for u	clar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal déath 3 🗆	Ectopic pregnand Other (specify) _	су		230	. Date of deliver Month	y Day Year
P.O.	t the c	hys	9 Unknown	9□ Unknown							
	law requires that the death as been signed by the atter 2 should be detached for u		Part II. Other significant conditions of	ontributing to death but not	t resulting in the ur	nderlying cause g	iven in Part I.	23e. Did to	obacco use	contribute to the	cause of death?
ğ	en sig	Completed by	4 y/atems io	\sim				1 🗆 Y	′es 2□N	lo 3 ☐ Proba	bly 4 □Unknown
000	law re as be 2 sho	piet						24a. Was	an 2	4b. Were autop	sy findings available
Ä	The ate his	E						autop perfor	rmed?	prior to com death? 1 Yes 2	pletion of cause of
ita	ian: ntifica	Bec	25. Was case referred to medical examiner?				26. Place o	f Death (Check only o		10165 2	5 NO
<u>5</u>	Physician: this certific ral director,	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3□ DOA Ot	ther: 4 Nurs	ing Home 5 ☐ Resid	ence 6 🗆	Other (Specify)	
ב	ing P	 	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	z8b. Time of Injury	28c. Inju Wo	iry at	28d. Describe h	ow injury od	curred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No				
Division of Vital Records,	tal or Al	Certification:	4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (S City or Tow	treet and Ni m, State)	umber or Rurai	Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai	29a. Certifier (Check only one) 1. Certifying Ph 2. Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred at the trestigation, in my	ime, date and popinion, death	place, and due to the o occurred at the time, o	ause(s) and date and pla	d manner as sta ce, and due to t	ted. the cause(s)
	To the To the Comp.		29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date si	gned (Month, D	ay, Year)
						10	0622	3	5/1	2/06	
	1		30. Name and address of person who							1	
SH	19+1			BOLARUM 340		REET, HA	GERSTON	N, MD 217	40/ 3	01-739-	7100
	Sta Registr	- 20	31. Date filed (Month, Day, Year) MAY 15 9	32. Registrar's S	ignature	ale					

			1 - For Stata Registrar	State of Marylar		artment of I			giene 006	17120
Ž	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
14	/Medic	al	Khalil Lolatchy 4a. Facility Name (If not institution, give s	street and number)		4h City Town	or Location of Dea	May 14		5:30 P M
	Examir	er	14717 Chisholm Lan			Gaither		101	Montgo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr	. (Month, Da	th 9. 8	inthplace (State or Foreign Country)
2:	Director		Usual Residence of Decedent	88	TIS.			11-8-19	17 Ham	edan, Iran
	arylane show	_	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	28a-f	ecto	MD Montgome 1 10e. Street and Number	ry Ga	ithers	ourg			10g. Citizen of What (1 X Yes 2 □ No
	h with	al Di	14717 Chisholm Lan	ding Way		208	378	ļ T	JSA	ounty?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel", or Iteme 23e or 28e-f ehow properate in the Traumatic event, Ite Medical Examples in the Indifficult and DDCs.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub		Specify Yes or No rto Rican, etc.)		ite, etc.
2-0	72 hor	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	tent's Usual Occup	pation	orkina	16b. Kind of Busines	s/Industry
12	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Owne	kind of work done OO NOT use retire	d)	onung .	Retail	
2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)	T	Owne		18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
ylan	should be and Mental s marked o umatic eve	ToB	Rahim Lolatchy					Morlah-		
, Mar	and 2 sh Balth and n 27 is m		19a. Informant's Name/Relationship (Typ Iran S. Bakhaj – W		19b. Mailin	ng Address (Street Chisholi	and Number or A n Landin	Bural Route Numbe g Way Ga	er, City or Town, State, ithersburg	Zip Code) MD 20878
Baltimore, Maryland 21215-0036	Pages 1 g ment of He ant: If Item ury or other)	20a. Method of Disposition 1 ☎ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation	amoust from State		sition (Name of natory or other pla emorial	^{CO)} 5-1	Date 6-06	20c. Location - City o Olney, MD	r Town, State
Balt	permit. Depertrimporte mporte eny inje		21. Signature of Fineral Service License	θ	1			_	l Funeral 11e, MD 20	
A. 19		9	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	th. Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory ai	rrest,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MULTIPLE CE		INFARCTS	3			5 YEARS
	Examiner		Sequentially list conditions.							
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	(uence of):					
oʻ	execu en and rial-tra	Exar	that initiated events c. resulting in death) Last	Due to (or as a consec	(uence of):					
8760	death certificate be executed e attending physicien and id for use as the burial-transit	dicai	C ₀							
Box 6	eath certific attending p for use as I	⊓/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn.					23d. Date of de	Niverv
P.O. B	st the death by the attended for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fets 4 Pregnant at time of c 9 Unknown		Ectopic pregnancy Other (specify)	<u>'</u>		Month	Day Year
	The law requires thet the tee been signed by the page 2 should be detached.	þ	Part II. Other significant conditions conf	tributing to death but not res	ulting in the un	nderlying cause giv	en in Part I.		obacco use contribute to the c	o the cause of death? robably 4 Munknown
Division of Vital Records,		Completed								utopsy findings available completion of cause of
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes X No	ospital:		3□ DOA Oth		ath (Check only o		
on of	Attending Physicien: or death. ector: After this certification by the funeral director,	ition: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c Injur Wor	4 🗆 Nursing r		lence 6 Other (Spenow injury occurred	ocify)
DIVIS	al or Attes s after des al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and Number or R m, State)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 X Certifying Physic (Check only one) 2 ☐ Medical Examin	ician: To the best of my known; On the basis of examination and manner stated.	wledge, death ition and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
l	. 1	Σ	29b. Signature and title of certifier	3	10	29c. Licens	e number D00093		29d. Date signed (Mon 05/15/200	
,	16		30. Name and address of person who cor	poleted cause of death (Item	23a) (Tuna 5	Print			05/15/200	•
			ROBERT F. BYRNE, MD	2333 S. NA	SH STRE	ET, ARLI	NGTON, V	A 22202		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 16	32. Registrar's Signa	iture /	porte				

			1 - For State Registrar	State of Ma		artmer			and Mental	Hygier	601	16	1712
			Decedent's Name (First, Middle, Last)						2. Date 0	f Death		3	3. Time of Death
	Physi		• Emanuel grancis	Livaudai	s Jr.				Month		006	ear	2:41 A M
	/Med Exam			treet and number)		4b. City,	Town, or	Location of			c. County of		-• 71 A
П			Suburban Hospita	1		Beth	nesda	a		M	ontgom	erv	
	Funera	al	Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under	1 Year Days	If Under	24 Hrs. 8. Date of	f Birth , Day, Yea			(State or Foreign
	Directo	r		M 2□F	74 Yrs.	Months	Days	Hours	Oct 2	9 193	Ί L	ouisi	
	p k		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	contina						101	Inside City Limits
	eho ed el	ŏ											ty⊠Yes 2 □ No
	the N	Director	10e. Street and Number	Ly	Po	otomac 10f. Zip			-	10- (NAT 4 1 4 ft -		
	with po or	ā				101. 21	2085	: /ı		-	Citizen of Wha	•	
	ne 23	era	10818 Nantucket To	errace 2. Was Decedent Ev	ver in U.S. 13	Was Dece			gin? (Specify Yes o		ted St		Indian
· ^	fter d	Funeral	1 Never Married 2 Married	Armed Forces? 14 Yes 2 □ No		If Yes, spe	cify Cuba	n, Mexican	, Puerto Rican, etc)	Black, 1	White, etc.	indian,
8	urs a	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1	1955	1 Tes	⊉ OXNo	Specify:			Specify.W	hite	
Ò	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow ta Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	eation	16a. Dece	dent's Usu	al Occupa	ation	-4	16b.	Kind of Busin	ess/Indust	ry
21	thin 7	ajac	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT u	se retired) most	of working	At	lantic	Rich	field
2	ed wi	ő		4	Lobb	yist				0i	1 Compa	any	
בַ	be fill d off	Be	, 17. Father's Name (First, Middle, Last)						r's Name (First, Mi				
₹	Men Merke Marke	ျ							Beatric				
Maryland 21215-0036	2 sh and and Is rr		19a. Informant's Name/Relationship (Typ						r or Rural Route N				de)
	1 and 1eaith em 27		Dona H. Livaudais 20a. Method of Disposition	/ Wife	1081 20b. Place of Disp	8 Nan	tuck	et Te	rr. Potor				
وّ	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Experience must be recilled at		1 Burial 2 □ Cremation 3 □ Re	emoval from State	cemetery, cre	matory or o	ther place				Location - City		
Baltimore,	rtant njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License						ay 18 20(Joseph (06 Fa:	riax V	/irgi	nia
Ba	Depa Depa Impo eny i	N N	1///4/20/		5	$130~\mathrm{W}$	isco:	s or Facility nsin	Ave. NW W	lachir	s Sor	nc 20	C.
			23a Part 1 Enter the disease or complic								ig con,		proximate
*			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	•					our dido or Toophiato	ry arrest,		Inte	erval Between set and Death
П	Physiciar /Medica		disease or condition resulting in death)		Myelogeno consequence of):	us Le	ukem:	ia				10_	Years
Н	Examine	r			consequence or,								
		ية ا	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consaquante of):							-	
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events										
Ö,	e exe ien ar ırial-t	Ä	resulting in death) Last	Due to (or as a	consequence of):								
8/60	licate be executed physicien and s the burial-transit	Physician/Medical	d.									N	
9	ing p	Mec	IF FEMALE:										
ROX	eath certifi ettending I for use as	an L	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	∃Ectopic pr					23d. Date of Month	-	Vans
- -	by the e	1 05	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death 5[Other (sp	ecify)			-	MOHUI	Day	Year
٦.	law requires that the death certifi as been signed by the ettending 2 should be detached for use as			ributing to death but	not resulting in the u	nderlyina c	ause auve	n in Part I	23e [lid tobacco	use contribut	te to the ca	use of death?
ecords,	signed to	d by		3	3 3								4 DUnknown
ဂ္ဂ	w require	eted C								-	-		
ě	5 4 8 6	Completed							a	/as an utopsy erformed?	prior deat	to comple	findings available tion of cause of
VItal	F # 8								1 🗆 Ye	s 216 N	1 0	Yes 2□	No
	ysicien: is certific director,	98	examiner?	ospital:	2 🖾 ER/Outpatier	* ° \	Othe		of Death Check or				
0	Phy or this eral d	IJН	C	28a. Date of Injury (Month, Day)			8c. Injury Work	4 🗀 1401	sing Home 5 F		6 UOther (5	Specify)	
<u></u>	7 2 4 2 -	i i	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	Year) Injury	М		? 'es 2 □ N			,		
DIVISION	Attendar death ector:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	/- At home, farm, str	eet, factory	, office		28f. Locatio	n (Street a	nd Number o	r Rural Roi	ute Number.
5	s afte	Certific	, G. vamais	building, etc.	(Specify)				City di	Town, Stai	θ)		
	nod hou	Sa C		cian: To the best of	my knowledge, deat	h occurred	at the time	e, date and	place, and due to	he cause(s) and manne	r as stated	
	0 0 0	Medi		and manner state	ed.				. Journal at the th				
	5 ¥ 5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	202	29b. Signature and title of certifier	A/-	A)A)	29c	. License	_		29d. Da	ate signed (M	onth, Day,	Year)
١	5	Ŧ	Kennel	K CA	aute	$ \downarrow$ \downarrow	100	172	1/	5	1141	06	
v	1	2	30. Name and address of person who con	_									
	-	4	Kenneth Goldstein N 31. Date filed (Month, Day, Year)	<u>1D</u> / 2141 32. Re istrar'	K St. NW	#707	Wash	ingto	n. DC 200	37	W600 - 0 - 0		
	S Regis	tate trar		00F	J. J. A	profe							

			For State Registrar	State of	Marylar		artment <i>tificate</i>			and Me	ental Hy	giene Reg. No.	06	17122
	Dharisi		1. Decedent's Name (First, Middle,	Last)						:	2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		Albert Layne								May 12	2, 2006		9:00 a ^M
	Examin	ıer	4a. Facility Name (If not institution,		ber)				Location o	of Death			nty of Death	
			5109 Bradley Bot 5. Social Security Number		Ann In ure	last birthday)	Chev If Under	•	ff Under	24 Hrs	8. Date of Bi		gomer	
	Funeral Director		(none)	18 M 2□F		54 Yrs.	Months	Days	Hours	Min.	(Month D	1941	Cor Tri	nplace (State or Foreign intry) nidad
	70		Usual Residence of Decedent								CPC.			
	how	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Be-f	cto	Maryland Montgo	nery	Chev	yy Chas								1 ☐ Yes 2 ☐ No
	Nith th	Director	10e. Street and Number	1 1			10f. Zip					10g. Citizen o		untry?
	eath v	era	5109 Bradley Bot	11evard	ent Ever in II	18 12 1	2081		enanio Orio	ain? /Sana	ify Voc or N	Trinida		ican Indian,
10	ter d	Funeral	t Never Married 2XXVarrie	Armed Ford	es? XNo	1				, Puerto Ri	ify Yes or Nican, etc.)		lack, White	, etc.
93	urs a	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			∏Yes 2	No No	Specify:			Spec	eify: Blac	ck
ည	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Iteme 23a or 286-f ehow ant, the Madical Esonomer must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual	l Occupat	tion	t of working	7	16b. Kind of		
7	ithin	du du	Elementary/Secondary (0-12)	College (1-	for 5+)	life. I	OO NOT us	e retired)	,		9	ъ.		
7	lled w tygier ther ti	ပိ	12 17. Father's Name (First, Middle, La	act)		Secur	ity G			do Namo /	(Eint Middle	. Maiden Suma		Services
Maryland 21215-0036	ntal h	Be	Carl Ramdial	131)							. Layne		11110)	
2	should bd Me mark mati	ဥ	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	a Address					er, City or Tow	m. State. Zi	in Code)
Ž	nd 2 :		Candace Layne/da	nighter								se, MD		, ,
Baltimore,	of Her item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of	,	Da		20c. Location		own, State
Ē	Page nent c int: if		1 ☐ Burial 2 🕅 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			esapeak				05/17	/06	Beltsv:	ille,	Maryland
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e-f ehow any injury or other traumatic event, the Madical Examination at any injury.		21. Signature of Funeral Service Li	genseen L/		G ²²	Name and	d Address OME	ct Facility	ation	Servi	ice P.0	O. Bo:	x 784
_	20 E 2 3		Devel X H	elitte	MO125	51 Be	verly	L	Hecki	rotte	P.A.	Clarks		e, MD 21029
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that car nly one cause on ea	ch line.	1_	1	of dying,	, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	PI	OST	ate		(AN	ICE	R		- 1	Inset and Death
	/Medical Examiner		rosuming in assum)	Due to (o	r as a conseq	juence of):								/
	15	<u>ت</u> ا	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a conseq	ruence of):								
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	exectan an	Exa	resulting in death) Last	Due to (o	r as a conseq	juence of):								
8760,	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d										
9	ing ph	Med	IF FEMALE:											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	Ideath 3	Ectopic pre						ate of deliv	rery Day Year
Р. О.	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□Unknov	nt at time of d vn	leath 5∟	Other (spe	icify)						
	that the de led by the a detached t	F.	Part fl. Other significant condition	s contributing to dea	th but not res	ulting in the ur	derlying ca	use giver	n in Part I.		23e. Did	tobacco use co	ntribute to	the cause of death?
ds	w requires that been signed to should be det	d by									10	Yes 2.0 No	3 Pro	bably 4 □Unknown
<u>ဂ</u>	s bee	Completed									24a. Was	an 24b	. Were aut	opsy findings available
æ	The law te has age 2 t	E									auto perfo	ormed?	death?	opsy findings available ompletion of cause of
<u> </u>	ysicien: The is certificate his director, page	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check only			2410
<u>></u>	Physic this ce al direc	2	1 ☐ Yes 2 ☑ No			ER/Outpatien	3 DO	Other	4 □ Nur	rsing Home	e 5 Resi	dence 6 🗆 O	ther (Speci	fy)
ū	Attending Physicien: r death. ector: After this certifice by the funeral director. I		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of fnjury		3c. Injury a Work?			d. Describe	how injury occu	urred	
Sio	tend death tor: /	cat	2 Accident investiga 3 Suicide 6 Could no	t be One Blace o	f Injury At h		M		es 2 N		of Location (Carnet and Mar	D	(8
Division of Vital Records,	f or Attenation after deat Director: in by the	Certification;	4 Homicide determin	ed building	, etc. (Specif	ome, farm, stre	eet, ractory,	OTTICE		20	City or To	wn, State)	10 6 F OF HUR	al Route Number,
	ospite hours uneral ly filled		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	wledge, death	occurred a	it the time	, date and	d place, an	d due to the	cause(s) and n	nanner as :	stated.
	1 2 T = 9	ledical	one)	caminer: On the bas and manne	is of examina	ition and/or inv	estigation,	in my opi	nion, deat	h occurred	d at the time,	date and place	a, and due t	o the cause(s)
	To the within To the	Σ	29b. Signature and title of certifier	1		7		License		1/		29d. Date sign		
0)a25		Whouse		M	D		J)	>10	16		MAT	15,	2006
15)~		30. Name and address of person w	no completed cause	of death (Iten	n 23a) (Type, I	Print)	υ A	Ve =	#13	20 1	U+V+(HASH	2006 MD 20815
	Sta	te	31. Date filed (Month, Day, Year)	32.	gistrar's Signa	ature		- /1		-1 4 0	-10	1.		(2-1)0/3
	Registr	ar	MAY 17	2006	Que ,	b. de	10 1 to							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 11:05 A John Dimitri Macdonald May 2006 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death of Cecil Covaty Elleton Cecil HUSP M If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 1,1958 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months Min. 1 2 M 2 □ F WashingtonDC 217-88-3549 48 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 Stonegate Blvd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2€ No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Yes, Give Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Robert's Oxygen Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Macdonald Alexandra Economides 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna K. Macdonald/Wife Loch Lomond St., Bear, DE 19701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris Inc. May 15,2006 West Chester, PA ' 4 Donation 5 Dother (Specify) 21. Signature of Funeral Solvice Licenses 22. Name and Address of Facility Andrew G. Gee Funeral Home Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiad or respiratory arrest, shock, or hear failure. List only one cause on each line. 219A2ploximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepato-Renal Syndrone 5 deys 21 dess Hepatitis Alcoholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

Completed by

Be

2

Funeral

Director

item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic evant, the Modical Extention of the multiple at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural; or Itan any injury or other traumatic evant, the Medical Externi

Baltimore, Maryland 21215-0036

Physician/Medical Examiner certificate be executed

the attending physician and

use as the for been signed by page 2 completely filled in by the funeral

certificate

this

s after death.

within 24 hours a

or Attanding Physician:

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Completed

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Medical Certification: To

Division of Vital Records, P.O.

IF FEMALE:

25. Was case referred to medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

alcoholisa

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

2/5 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending

2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

00055190

May 13, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A Pino Hospital (06 Bow St Elkton, MD 21921 Alfred My Vyrou

31. Date filed (Month, Day, Year) State Registrar



		1 = For State Registrar	State of	Marylar	nd / Depa <i>Ce</i> a	artment of H rtificate of I	lealth an D <i>eath</i>	d Mental Hy	rgiene	06	17124
Physicia /Medic		1. Decedent's Name (First, Middle, La: SARAH MAI	_	MELV	12			2. Date of De Month	Day	Year 006	3. Time of Death 2045 M
Examin	er	4a. Facility Name (If not institution, given the MEMOR) 5. Social Security Number 6. S	AL I	405PI	TAL last birthday)		S NOW			LB0	
Funeral Director			M 2. X F	7. Age (iii y/s.	Yrs.	Months Days		Min. (Month, Da	rth ay, Year) 22,1928	9. Birthpl Count FLOR	
the Maryland r 28a-f ahow	Director	MD QUEEN A	NNE	10c. C	ty, Town or Lo				10g. Citizen of		Od. Inside City Limits 1 ☐ Yes 2 💆 No try?
filed within 72 hours after deeth with the Maryland Hygiene. Hygiene 1980 or 288-f ahow ont, the Medical Evarifrer must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Amed For 1 Tes If Yes, Giv Year or Da	rces? 2 📉 No e			21617 spanic Origin n, Mexican, P Specify:	? (Specify Yes or No ruerto Rican, etc.)	o- 14. Rad	USA ce - America ck, White, e	
s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic avent, Ira Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle, Last)	de completed) College (1 -0-	-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	furing most of () RK	working Name (First, Middle		OSTAL	SERVICE
2 should be filed withing and Mental Hygiene. is marked other than surmatic avent, the manner.	To Be	WALTER BALDWIN 19a. Informant's Name/Relationship (19h Mailir	ng Address (Street	H	BERTHA KUF	IN		Code
1 and 2 s Health an tam 27 ia		WILLIAM E. MELVIN 20a. Method of Disposition	* .	20b.	326 I	OULIN CLAI	RK ROAI	D, CENTREY		D 216	17
t. Page dment or dant: if		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Fundal Service Licental Service Lice	1)	State CH	ceme <i>tery</i> , cred ESAPEAR NTER, I	matory or other place KE CREMAT LLC		-11-2006	STEVENS	,	
Departiment in the control of the co		23a. Part1. Enter the disease, or com	1/e	2	. FF	18 S. I.TRI	LFENBEJ ERTY SI	IN & NEWNA	CVILLE.	MD 21	617
Physician /Medical Examiner bhysicien and bhysicien and the portal-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	TYPER or as a consec	KALEA quence of): AGE quence of): TIVE 1						Approximate Interval Between Onset and Death
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		rth 2 ☐ Feta ant at time of o	al death 3	Ectopic pregnancy Other (specify)				te of deliver	y Day Year
w requires that been signed b	ρ	Part II. Other significant conditions of CORDNARY	ontributing to de		sulting in the u		en in Part I.	23e. Did t		ribute to the	e cause of death?
ician: The law re certificate has be rector, page 2 sho	Completed	SMALL CEL	L CAN	ICER	of Lu	NG		24a. Was auto perfo 1 Yes	psy prmed2	Were autop prior to com death? 1 \(Yes \(2	sy findings available aptetion of cause of
ng Phye fter this	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury ome, farm, str	28c. Injury Work	or: 4 ☐ Nursin		dence 6 □Oth how injury occurr	red	
To the Hospitel or Atlandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the niner: On the ba and mann	sis of examina	owledge, death ation and/or in	h occurred at the tim vestigation, in my op	e, date and pl sinion, death o	lace, and due to the occurred at the time,	cause(s) and ma date and place, a	anner as sta and due to t	ited. the cause(s)
To t To t com,	Σ	29b. Signature and title objectifier	mi	MD		29c. License			29d. Date signed 05/10		-
5 KK Sta	10	30. Name and address of person who DR - 0/3A4/0WI() 7 31. Date filed (Month, Day, Year)	NEMORI	of death (Iter AL HOSP egistrar's Signa	17AL, 8	Print) PA STON,	MD 2	1601			
Sta Registra	_		2006	E.	L	1 .					

06-03127 William Miller

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	f Death	Re	g. No. 200	6 1/12
Physicia		1. Decedent's Name (First, Middle,Last)			2. Date of Death	Day Year	3. Time of Death 1000 hrs
Medical Examii	ner	William Randall Miller 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of	May 9, 200	4c. County of Death	1000 1113
		Baltimore Washington Medical Center		Glen Burnie		Anne Arundel	
Funeral Director		464-55-5324 1XM 2F	yrs. last birthday) 40 yrs	Months Days Hours		h(MM/DD/YYYY) 9. Birt 1966 Foreig Cou	Washington Washington JC
any	H	Usual Residence of Decedent 10a State 10b County 10c.	. City, Town or Local	tion			10d Inside City Limits
<u> </u>	ţ	MD Anne Arundel		Severna Pa			1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 706 Pin Oak Road		10f. Zip Code 21146	10	g. Citizen of What Coun	try?
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene rked other than "natural", or items 23a or 28a-f shrent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year	lf Y	as Decedent of Hispanic Origon Y es, specify Cuban, Mexican, Y es 2 X No specify:		White, etc.	an Indian, Black,
ours afte	g S	15. Decedent's Education (Specify only highest grade complete		nt's Usual Occupation (Give i		16b. Kind of Business/Ir	
5-0036 Thed within 72 hou Hygiene d other than "nai	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	,	nost of working life. DO NOT ect Manager/B	·	RT Vane Builders,	Inc.
21215-0036 Auld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle, Last)		18.Mother	's Name (First, Middle, M	faiden Surname)	
21218 buld be fill Mental H marked c event, t	Be	Cecil Miller 19a. Informant's Name/Relationship (Type, Print)	19h Mailir	g Address (Street and Num	para Lester	har City or Town State	Zin Code)
MD 2 d 2 shoul tth and N n 27 is n numatic	٩	Diane Marie Miller/Wife		Pin Oak Road,			
	- [20b. Place of Dispos crematory or of	sition (Name of cemetery, ther place)	May 15,	20c. Location - City or	Fown, State
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:		Crematory	2006	Baltimore,	MD
Baltimo permit Page Department of Important: injury or otd		21. Signature of Funery Service Loursee	22.	Name and Address of Facility Seyen		- Hold	
Physician /Medical		23a. Part f. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter	the mode of dying, such as c	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque					Death
Andrew - more		Sequentially list conditions,	,				
	iner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause	ince of):				
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a conseque	nce of);				, i
executed ian and ial - transit		UNPENDED AMENDED					
1760, ficate be exe g physician a	Med	IF FEMALE: 23c. If yes, outcome or				23d. Date of delivery	
Sox 687 leath certifit e attending for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time	af do ath	etal death 3 Ectopio	pregnancy	Month D	ay Year
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that the defended by the	by P	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause given in Pa		bacco use contribute to t	
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COTC law re has be	Completed				autops	med? death?	ompletion of cause of
tal Rec ian: The certificate ector, page		25. Was case referred to medical		26. Place of Death	(Check only one)	No 1 Ye	s 2 No
/ita/ ysiciar his cer direct	o Be	eveminer?	2 ER/Outpatien	. Others		Residence 6 Other	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of			low injury occurred	
Sior Attend death cetor:	catic	2 Accident Investigation	At home form stre	1 Yes 2		treet and Number or Ru	el Bouto Number City
Division pital or A cours after ceral Direction of the ceral Direction of the ceral Direction of the ceral Direction of the ceral Direction of the ceral Direction of the ceral Direction of the ceral Direction of the cera	Certification:	3 Suicide 6 Could not be determined (Specify)	- At nome, farm, sire	eet, factory, office building, et	or Town, Si		ar Route Number, City
Hos 24 h Fun tely	Medical Co	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examina					
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	th, Day. Year)
		Cangle MI		O.C.M.E.		May 10, 2006	
		30. Name and address of person who completed cause of death		nn Charat Dalling	MD 04004		
		Zabiullah Ali, M.D. Assistant Medical Exam 31. Date filed (Mori May, Year) \$ 2006 32. Assistant's S		nn Street, Baltimore, I	VID 21201		
S Regis	tate trar	Markit A O COUL	LAN A	20(13)			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jane D. McElree 11 Дм May 2006 1:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 108 Huse Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M XXF Yrs. 290-18-8648 86 Director 3/15/1920 Ohio Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Execution return the profiling at Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 108 Huse Drive 21403 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 2 No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iten any injury or other traumatic svent, the Michigal Exertinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify. Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bronson A. Durran Edna W. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen McElree/daughter 108 Huse Drive Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Buriat 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 5/18/2006 Columbus, Ohio 4 ☐ Donation 5 ☐ Other (Specify) Funeral * rv/ Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ecli ac disease or condition resulting in death) /Medical Due-to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 20 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy within 24 hours after death.

To the Funeral Director: After this neverse completely filled in here. 2 No 1 Yes 1 TYes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature a title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) State MAY 15 2006 Registrar

			For State Registrar	State of	Marylan		artment rtificate				ental Hyg	jiene leg. No.	006	17127
			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio	_	Purlene Mu								May	9	2006	16:26 M
	Examin		4a. Facility Name (If not institution				4b. City, 1		Location of				ounty of Death	
				nington Hos		la at hirth days	If Under		Ft. W		ngton 8. Date of Birth			eorge's
	Funeral Director		5. Social Security Number 579–36–1918	1 M 2 KF	. Age (<i>In yr</i> s. 78	Yrs.		Days	Hours	Min.	May 1,	, Year)	Sout	lace (State or Foreign try) :h Carolina
	pue M		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Lo	cation						1	0d. Inside City Limits
	f sho	5							• . 1	,				1∭Yes 2 □No
	the 28a-	Director	Maryland Prince 10e. Street and Number	e George's	3		10f. Zip		itlan	.d		I0g. Citize	en of What Cour	itry?
	3a or		4404 Re	na Road,	#101			2	0746				United	States
	deeti	ner	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.	Was Deced	_		gin? (Spec	cify Yes or No-		Race - Americ Black, White,	an Indian,
9	or Ite	교	1 Never Married 2 Marr	ed 1 TYes 2	No No	1	1 Yes 2			1, 1 40110 1	noarr, oto.,	1		rican
8	ural',	d b	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dat	es:								Am	erican
7	within 72 hours after deeth with the Maryland sne. then "natural", or items 23e or 28e-f show ha Maulcal Examinar mat be notified at	Completed by Funeral	15. Decedent (Specify only highes	t grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ition <i>luring</i> mos	t of workin	g	16b. Kind	d of Business/Ind	dustry
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Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan ertment of Heath and Mental Hygiene. ortant: If item 27 is marked other then "natural", or items 23s or 28s-f show injury or other traumetic event, the Medical Extrainer must be notified at it.		19a. Informant's Name/Relations				-						Town, State, Zip	Code)
	and and and and and and and and and and		Leonard Mur	ray/Son	1	_	The same of the same				Wash.	-		
ore	ges 1 r of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from St	late	Place of Dispo emetery, crea			- 1			20c. Loca	ation - City or To	wn, State
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Baltimore,	permit. Pages 1 Depertment of H Important: If ite eny injury or ot		21. Signature of Furreral Service	· CT	TIT	22	2. Name and						ral Homa h., DC	
			23a. Part1. Enter the disease, or	complications that can	used the death	h. Do not en							II., DC.	Approximate
8760,	Americal Examiner Transit the burial-transit the bu	icai Examiner	shock, on heart failure. List Immediate Cause (Final disease or con lition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Due to (o b Due to (o	CA	uence of):	AC	,	ART	RE	40	157	ASE	Interval Between Onset and Death
P.O. Box 687	iaw requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3[]Ectopic pre] Other (spe					23	d. Date of delive Month	ry Day Yваr
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<u>></u>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 X 0 No	Hospital: 1 🗆 In	patient 2)	₹R/Outpatier	nt 3 DO.	A Othe	0E 4 □ Nu	rsing Hom	e 5 🗆 Reside	ence 6 (Other (Specify)
0	ng Ph ter th neral		27. Manner of leath 1 Natural 5 ☐ Pendin	28a. Date of (Month	Injury Day Year)	28b. Time o	f 28	3c. Injury Work	at	21	8d. Describe h	ow injury	occurred	
Division of Vital	To the Hospitel or Attending Physician: The within 24 hours effect death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Certification:	2 Accident investig 3 Suicide 6 Could i 4 Homicide determ	not be 28e. Place of	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, sti	М	1 🗆 ነ	fes 2□		8f. Location (Si City or Town	treet and i	Number or Rura	i Route Number,
_	ne Hospitet 24 hours e ne Funeral D	edicai C	29a. Certifier 1 Certifyin (Check only one) Medical	g Physician: To the b Examiner: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, ar th occurre	nd due to the c d at the time, d	ause(s) ar ate and p	nd manner as st lace, and due to	ated. the cause(s)
	To the To the	Ž	29b. Signature and title of certifie	A 1	^		29c.	License	number	A 11	/ 2	9d. Date :	signed (Month, I	Day, Year)
)			•	4-11				W,	120	106	2	5	1/12	106
e	(2)		30. Name and address of person					Cen	ter [)r [Waldorf	, MD	20602)
	Sta Regist		31. Date filed (Month, Day, Year)	. Re	gistrar's Signa		B)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per Dr., G855 O5/31/06dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day 20<u>06</u> C **McCanns** MAY 15 1320

Physician

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	mine		a. Facility Name (If not in	stitution, give	street and number)			4b. City, To	wn, or Locat	tion of Death		4	c. County	of Death		
				AL HOSI					BERLA				ALLE			
Fune Direc			5. Social Security Number 235-34-164 Usual Residence of Dece	0 1	The second	e (In yrs. ias 30	Yrs.	Months D	ays Hou	nder 24 Hrs. urs Min.	8. Date of E Month, Dec	14, 1	925	9. Birthp	place (State or	Foreign
Maryland			10a. State 10b.	County Allegan	y	10c. City,		berland						1	l0d. Inside City	
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Z I Z I D-U 1 within 72 ho jiene. r then "netur		Completed	15. D (Specify only Elementary/Secondary	ecedent's Edu y highest grade (0-12)	cation e <i>completed)</i> College (1-4or 5	i4)	16a. Dece (Give life.		ecupation lone during etired)	most of workir	ng		Kind of Bus	siness/Ind	dustry	
I and I want the design of the		To Be C	17. Father's Name <i>(First,</i> J. Georg		t	<u> </u>				other's Name				e)		
Maryla Ind 2 should alth and Men 27 is marke		ĺ	19a. Informant's Name/Re Eileen Sear	elationship <i>(Ty)</i> I es	_{рө, Print)} daug	hter	19b. Mailir 28 E	ng Address (S Brownin	g Stre	umber or Rura. et	Route Num Cum	ber, City	or Town, S and	State, Zio	21502	2
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Department of Important: If	once.		21. Signature of Funeral S	Service Licens	The	10	(22			กัษ์Yal Ho Avenue:			d, MD 2	21502		
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ited		Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s, te	Due to (or as	a conseque	nce of):	chen	1100							
Geath certificate be executed death certificate be executed e attending physicien and after its as the burial-transit		ai Exa	that initiated events resulting in death) Last		Due to (or as	a conseque	nce of):									
Certificate adding phy		ysician/Medical	IF FEMALE: 23b. Was decedent pregr	ant 2	3c. If yes, outcome								23d. Date	of delive	anv	
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ION OT nding Phys ath. r: After this		ation:	27. Manner of Death 1. Natural 5 2 Accident	Pending investigation	28a. Date of Injur (Month, Day	y Year) 2	Bb. Time of Injury		Injury at Work? 1 ☐ Yes	2	8d. Describe				<u>′</u>	
DIVISION C 10 Hours after death. 10 Funeral Director: After the funeral private funeral process.		Certification;		Could not be determined	28e. Place of Injubulding, etc	ury - At home. (Specify)	e, farm, str	eet, factory, or	fice	2	28f. Location City or To	(Street a	and Number te)	r or Rura	Route Number	∋ <i>r</i> ,
To the Hospitel or Att. within 24 hours after de To the Funeral Direct		edicai	29a. Certifier 1 Check only 2 N	ertifying Phys ledical Examil	sician: To the best of ner: On the basis of and manner sta	examination	edge, death n and/or in	h occurred at t vestigation, in	he time, dat my opinion,	e and place, a death occurre	nd due to the	e cause(e, date ar	s) and man nd place, ar	ner as st	ated. the cause(s)	
To th To th		ž	29b. Signature and title of	certifier	(N			29c. L	cense numb	per		29d. D	ate signed	(Month, I	Day, Year)	
•		-	30. Name and address of	per n who co	mpleted cause of	eath (Item 2	3a) (Type,		57295			MAY	15,	2006		
			DR.ANDREW ST		924 SETON	DRIVI	E CU	MBERLAI	ND,MD	21502						
Rec	Stat gistra		31. Date filed (Month, Day	y, Year)	32. Registra	ar's Signatur	e Ales									
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:15 MILLER JANE , 2006 BETTY MAL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 25, 1927 1□M 2**X**□F 78 September Maryland Director 213-24-7957 Usuel Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Director Maryland Washington Hagerstown r 28a-f the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or itame 23a or Examiner must be 21740 U.S.A. Berner Avenue Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiane. Important: If tem 27 is marked other then any injury or other traument. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lester Lerov Lewis Leona Mae Smith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essie M. Miller Daughter In Law12602 Greencastle Pike, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 05-18-06 Rest Haven Cemetery 21. Signature of Funeral Service License Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Maryland 21740 poel Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hemispherre **Physician** /Medical Due to (or as a consequence of): Examiner engior Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed +Na to (or as a consequence of Box 68760. Physician/Medical use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Š signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has b irector, pege 2 s 1 ☐ Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 DEB/Outpatient 3 DOA this After this funaral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier Ou.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CORRECES WH-3 31. Date filed (Moi 32. Registrar's Signature State Registrar nache

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May Month 13 20ŎĞ 9:45A. **Physician** Esita N. Mukungu /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🂢 F 242-65-8828 86 Yrs. Uganda **Director** Usual Residence of Decedent 10d. Inside City Limits the Manyland 10a. State 10b. County 10c. City. Town or Location •how rthan "natural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at Durham 1 XYes 2 No North Carollina Durcham Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Eagle Ridge Court 27713 Uganda Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status nit. Pages 1 and 2 should be filed within 72 hours after tearment of Health and Mental Hygiene.
ioriant: If item 27 is marked other than "natural", or item
injury or other traumatic avent, the Medical Examina. 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kyaki Bossa Dina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 Eagle Ridge Court Durham, North Carolina 27713 Steven Mukungu -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bunamwaya, Uganda 5/22/2006 Bunamwaya, Uganda 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 landel Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed and physicien are the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4☐Pregnant at time of death ed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed; 2 ANO 2 No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1. Natural 5 Pending investigation after death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funarel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ş 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 14, 2006 D32332 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #220 Silver Spring, Maryland 20902 S.K. Gupta, M.D. 31. Date filed (Month, Day, 32 Angistrar's Signature State 2006 Registrar

			1 - For State Registrar	State of I	Maryland / D	epartmer Certifica			ind Me		giene Reg. No. 20	06	17	131
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	Physicia /Medic		Michael	A.		Mosta	jir		М	Month Lay 10,		Year	8:21	A^{M}
,	Examin		4a. Facility Name (If not institution,	give street and number	er)	4b. City	Town, or	Location of	Death	•	4c. County of	of Death		
			10500 Democrac	y Lane		Pot	omac				Montg	gomen	<u>cy</u>	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birth	Months	r 1 Year Days	If Under 2 Hours	Min.	. Date of Birt (Month, Day	h y, Year)	9. Birthp Coun	lace (State o	r Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside Cit	tv Limits
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anc	id be fi ental the ked of ic eve	Be	Gholamreza Mosta					Fakhr		Farno		9)		
Maryland		은	19a. Informant's Name/Relationsh		196	Mailing Addres	s (Street a				r, City or Town, S	State Zin	Code)	
Σ	and 2 sealth ar n 27 is ier trau		Lily M. Mostaji								MD 208		3030)	
an .	4 9 E E		20a. Method of Disposition		20b. Place of I	Disposition (Na	me of	-) 13.6	Dat	e	20c. Location - 0	City or To	wn, State	
Baltimore,	perrit. Pages 1 Department of H Important: If Ite any Injury or ot once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Memori	rklawn al Park			ay 12 2006		Rockvill	la N	farul a	n d
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1	/Medical		resulting in death)	a. Due to (or	as a consequence of): 0		1-4					ace	ans
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<u> </u>	endir sath. or: Af he fu	atle	2 ☐ Accident investig	ation		м		Yes 2 □ N	10					
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 289. Place of	Injury - At home, farr, etc. (Specify)	n, street, factor	y, office		28	f. Location (S City or Tow	treet and Number n, State)	r or Rura	Route Numb	ber,
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	To the Hospital or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	and manner	Stateu.	29	c. License	number			29d. Date signed	(Month. I	Day, Year)	
1	750		91,100	4	to 111		_	1105	71	arg	5/1N	61.	,,	
•			30. Name and address of person v	on completed cause	of death (Item 23a)	wne Print\	×	. 100	- V		2/14	22	205	
			William G. Fran				Masc	n Dri	ve, S	Suite 1	07, Ar1:			
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	1.0	e							
	Registr		MAY 16	2006 32. Beg	aux St.	Sparke								

			State of Maryla						-	_	
			For State State Registrar		rtificate			nu ivie		a. No. 2 0 0 (5 17132
*		, a	Decedent's Name (First, Middle, Last)					2	Date of Deat	h	3. Time of Death
5,50	Physici /Medic		Isaiah McNeill						Month May	10,200	6:15 a ^M
-	Examin		4a. Facility Name (If not institution, give street and number)				Location of	Death		4c. County of D	eath
	2. *	21 A	Southern Maryland Hospita		4-	nto		411		1	Georges
\$.	Funeral Director		242-54-6370 ^{183 M 2□ F} 71	s. (ast birthday) Yrs.	If Under Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, June 28	Year)	Birthplace (State or Foreign Country) ad Springs, NC
	and and		Usuel Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo	ocation						10d. Inside City Limits
	Mary	tor	Virginia Arlington								1 □ Yes 2 🖔 No
	h the	Funeral Directo	10e. Street and Number		10f. Zip	Code			11	ng. Citizen of What	Country?
	23a c	rai	2021 N. Nelson Street, Ap							USA	
	er deg	nne	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede If Yes, speci	ent of His ify Cubar	spanic Origi n, Mexican,	in? (Spec Puerto Ri	fy Yes or No- can, etc.)		American Indian, Vhite, etc.
36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No.	Specify:			Specify:	Black
Ş	within 72 hours after death with the Maryland ene. Than "raturel", or items 23a or 28e-f ehow Le Madical Examiner must be notified at	ted	15. Decedent's Education	16a. Dece	dent's Usua	Occupa	tion	- 6		16b. Kind of Busine	
215	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)		kind of won DO NOT us						- Deelesship
2	filed wi Hygien other th			Custo	omer					AUTOMODILO Maiden Sumame)	e Dealership
Maryland 21215-0036	9 7 5 P	To Be	17. Father's Name (First, Middle, Last) Henry McNeill					,	wn Mcl	,	
	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatic		19a. Informant's Name/Relationship (Type, Print) Reba M. Nettles / Daughte		-					City or Town, Statendon, V	
Baltimore,	of Head		20a. Method of Disposition 20b.	Place of Dispo	osition (Nam matory or ot	e of her place)	Da	te 2	20c. Location - City	or Town, State
Ħ H	permit. Pages Department of I Important: If Its any injury or or		4 □ Donation 5 □ Other (Specify) MC	. Comfo						Alexandı meral Se	ria, Va.
Bal	Depar Impo		21. Signature of Funeral Service Licensee	P.	.O. Bo	x 39	7,Pur	cell	ville,V	irginia 2	
6 9			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode	of dying	, such as ca	ardiac or	espiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		reculting in death)	yocaro	tial.	1n f	arct	10n			HOURS
*	Examiner		Due to (or as a consc	equence of): 14Per 1e	nsio	n					YEARS
		her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	1 /	,,,,,,						
	be executed sician and burial-transit	Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events c								
760,	be executed ician and burial-transit		resulting in death) Last Due to (or as a conse	equence of):							
6876	6 % 6	dicai	d								
	certifi ding p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg	nancy						23d. Date of	delivery
B	d for u	ciar	in the past 12 months? 1 Vac 2 No. 1 Vac 2 No.	tel death 3	⊒Ectopic pre ⊒ Other (s <i>p</i> e					Month Month	Day Year
o.	tache	hys	9 Unknown								
Division of Vital Records, P.O. Box	The law requires that the death certifica sie has been signed by the attending phy page 2 should be datached for use as th	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not re Congestive reart failure	esulting in the u	inderlying ca	use give	nin Part I. 11 a tio	on			e to the cause of death? Probably 4 \int Unknown
000	s beer s beer s shou	olete	Chronic kidney disease	ON	dialy	1515			24a. Was an	24b. Were	autopsy findings available
æ	The la	mo;	Cribial vascular accid		{				autopsy perform	egf? death	to completion of cause of 1? /es 2 No
<u>ta</u>	sian: artifice ctor.	Bec	25. Was case referred to medical examiner?					of Death (Check only one		
<u>></u>	hysic this ca al dire	ျ	1 ☐ Yes 2 No Hospital: 1 Alnpatient 2				4			nce 6 Other (S	Specify)
UC C	After After funer	ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time o	of 28	Bc. Injury Work	at ? ′es 2.∐No		d. Describe ho	w injury occurred	
İSİ	Attending Physician: or death. ector: After this certifice by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At	home, farm, st			63 2 110		f. Location (Str	eet and Number or	Rural Route Number.
<u> </u>	s after el Dire	Certification:	4 Homicide determined building, etc. (Spec	cify)	,				City or Town	State)	
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examination and manner stated.	nowledge, deat nation and/or in	th occurred and oc	at the time in my op	e, date and inion, death	place, an occurred	d due to the ca at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c.	License			29	d. Date signed (Mo	
)	2		P. Sindheward			DO	0616	14		5/11	106
			30. Name and address of person who completed cause of death (It								
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 6 2006			, ,					
1100	200 W		Not Black								

		-	State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygier	4 U U O	17133
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Michael Charles Manning		Month D May	15 Year 200	06 7:00 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			24990 Sunset Ave.	Greensboro		Carolin	
T	Funeral		5. Social Security Number 6. Sex 1 1 1 M 2 F 7. Age (In yrs. last birthday 1 7 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 27	9. Bir	thplace (State or Foreign ountry)
'n,	Director	-	167-38-3385 53 115. Usual Residence of Decedent		March 27	1953 Wa	shington, DC
	/land	Ì	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Many B-f eh	ţċ	Maryland Caroline Greensbe	oro			1 ☐ Yes 2Ã No
	or 28	Directo	10e. Street and Number	10f. Zip Code		Citizen of What C	ountry?
	23a	Ta .	24990 Sunset Ave.	21639		JSA	
	er de	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	rs aff	by F	1 🕅 Never Married 2 □ Married 1 □ Yes 2 🖺 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Wh	ite
Ş	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28a-f show he Medical Examinar must be molilled at		15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	Kind of Business	/Industry
215	hin 7.	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)			
2	filed wil Hygien Sther th ent, the	Completed	<u> </u>	ck driver		ntract t	rucking
D D	d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	len Sumame)	
3	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. In marked other then "natural", or liteme 23a or 28a-1 show aumatic event, the Marical Exement must be notified at	ဥ	Charles H. Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Ida E. ling Address (Street and Number or Run		v or Town State	Zin Code)
Maryland 21215-0036	d 2 st th and t7 le r			90 Sunset Ave. Gre			
ē,	Heal Heal tem 2	7	20a Method of Disposition 20b. Place of Disp			Location - City or	
ē	Peges ent of nt: If i	i		ke Cremation Cn 5/2	20/06 Ch	ester, M	Maryland
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic as <u>once</u> .		21 Signature of Funeral Service Licensee	22. Name and Address of Facility Leegle and Helfenber D Box 160 Greensbo		11 Home	
			23a, Part1. Enter the disease, or complications that caused the death. Do not en			139	Approximate
	Dharaisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	a They was and	N is	im	Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. VENTRICULA Due to (or as a consequence of):	R TACHYCAR	DIP	1111	
	Examiner		HYPBRTENS!	on			15/19/12
	7 0 ₹	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cate be executed oblysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	be ex icien burial	a E	5 5 5 6 (5) 43 4 3 5 (5) 4 4 5 (5)				
687	physics by sthe	dicai	d				
Box (nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery
m	that the death certific ed by the attending p deteched for use as	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
Р. О.	at the by th	hys	9 Li Unknown				
	es the	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc		o the cause of death?
ord	w requir been si should	ted					
Rec	2 2	Completed			24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
ā	vicien: The lav certificate has rector, page 2	ပိ	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 ☑ h (Check only one)	No 1∐Ye.	3 2□ No
5	Physicien: r this certificant ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other	me 5 Residence	6 □Other (Spe	ocify)
0	ig Phyter thi		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how in	njury occurred	
<u>S</u>	Attending r death. ector: After by the fune	atic	2 Accident investigation	M 1 Tyes 2 No			
Division of Vital Records,	l or Att efter d Direct i in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the best of my				
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mon	th, Day, Year)
)	. > - 0		· C.W. Gam	D0000250		5/16/0	<i>p.</i>
			30. Name and address of person who completed cause of death (Item 23a) (Type C. BAN, 609 DUTCHTIPM		ON, MD	, 2160	
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	**			
2	Regist	rar	MAY 1 7 2006 A 1999 A	wants!			

			1 = For State Registrar	State of Ma	-	partment of e <i>rtificate o</i>		Mental Hygi	iene 006	17134
	Physici		1. Decedent's Name (First, Middle, Last) Norman Francis		М	cCeney		2. Date of Death	4, Day 2006	3. Time of Death 5:35A. M
	/Medic Examin		4a. Fecility Name (If not institution, give s Renaissance Gardens (1) R	treet and number) Riderwood Vi	llage	4b. City, Town Silver	or Location of Dea Spring	th	4c. County of Deat Prince G	eorge's
Ī	Funeral Director		5. Social Security Number 6. Sex 579-10-6378	7. Age	(In yrs. last birthda 84 Yrs.	Months Day			9. Bird Was	hplace (State or Foreign Kington, DC
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	eorge's	10c. City, Town or Silver S					10d. Inside City Limits
	h with the 23a or 28a st be roti	al Director	10e. Street and Number 3110 Gracefield Roa	ad, #1435		10f. Zip Code	20904	10	og. Citizen of What Co United S	
920	be filed within 72 hours after death with the Maryland tial Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Eraninal must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □XYes 2 □ N If Yes, Give Year or Dates:	0	I. Was Decedent of If Yes, specify C	of Hispanic Origin? (suban, Mexican, Pue no Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	e filed within 72 ho al Hyglene. other than "natur vent, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary 10,12)	cation completed) College (1-4or 5-	(Giv	. DO NOT use ret	ne during most of wo	orking	leb. Kind of Business/	
land 2	ould be filed Mental Hygis wrked other latic event, L	To Be C	17. Father's Name (First, Middle, Last) Victor		Mc	Ceney	18. Mother's Na	me (First, Middle, M		hatz
	permit. Pages 1 and 2 should be Department of Health and Mental important: if item 27 is marked c any injury or other traumatic ev pnce.		19a. Informant's Name/Relationship (Ty) Karen Belton -daugh		1762	Charles		lersville	City or Town, State, Z , Maryland	
Baltimore,	Pages 1.		20a. Method of Disposition 1 8urial 2	emoval from State		ematory or other p			Silver Spr	Town, State ing, Marylan
Balt	permit. Depart import any inj		21. Signature of Funeral Service License	apost	e 4	400 Powd	er Mill R		ville, Mar	yland 20705
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Athero	sclerotic a consequence of): a consequence of):			c or respiratory arre	St,	Approximate Interval Between Onset and Death 1 year
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last		a consequence of):	-				
.O. Box	that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 24□Pregnant at 9□Unknown	2 Fetal death 3	□Ectopic pregna □ Other (specify)			23d. Date of deli Month	ivery Day Year
<u>α</u>	sigr d be	by	Part II. Other significant conditions con	tributing to death bu	at not resulting in the	underlying cause	given in Part I.	1	acco use contribute to s 2 ☐ No 3 ☐ Pro	57
al Records,		Completed							prior to death? A No 1 □ Yes	topsy findings available completion of cause of
ion of Vital	ling Phy I. After this uneral di	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	nt 2 ER/Outpati y 28b. Time r Year) Injury	of 28c. ir		eath (Check only one Home 5 Resider 28d. Describe hor	nce 6 Other (Spec	cify)
Division	ital or Attend rs after death al Director:	Certification:	3 Suicide 6 Could not be determined	building, etc				City or Town,	, 	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Examinations)	sician: To the best oner: On the basis of and manner star	examination and/or	investigation, in m	y opinion, death occ	urred at the time, da	use(s) and manner as te and place, and due	to the cause(s)
1	271 241	M	29b. Signature and title of certifier P	ethum	ang, M	D 29c. Lice	9952H		5 - 15 - 20	
_			30. Name and address of person who co Loveen Puthumana,	M.D. 3110	Gracefie	ld Road	Silver Sp	ring, Mary	yland 20904	4
	Sta Registi		31. Date filed (Month, Day, Year) MAY 16 20	32. jegistra	r's Signature	banker				

		. For		f Marylar						-	giene	ne.	1 77 1 0 7
		State Registrar			Ce	rtificate	e of L	Death			Reg. No. U	16	1/135
Physici	an	Decedent's Name (First, Middle, La	st)						2.	Date of Dea Month		Year	3. Time of Death
/Medic	al	Lee Burton Mul 4a. Facility Name (If not institution, give	lins	mbor)		4h City	Town or	Location o	of Death	05	4c. County of	D(g	09 70"
Examin	ier	_Memorial Hospita					asto		or Douit		Talbot		
Funeral		5. Social Security Number 6.5	Sex	7. Age (In yrs.	. last birthday)		1 Year	If Under		Date of Birtl (Month, Day	h /. Year)	9. Birthp	place (State or Foreign
Director		230-18-3191	1 X M 2□ F	82	Yrs.						1923	Virg	inia
and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	Od. Inside City Limits
Mary -1 eho	to	Maryland Caroli	ne	De	nton								1 ☐ Yes 2X No
in the	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of W	hat Cour	ntry?
ath wi	ral	25770 Burrsville	· · · · · · · · · · · · · · · · · · ·			216					USA		
er des	une	11. Marital Status	12. Was Dec Armed Fo		J.S. 13.	Was Deced If Yes, spec	lent of Hi ofy Cuba	ispanic Ori n, Mexican	gin? (Specify n, Puerto Rica	y Yes or No- an, etc.)	14. Race Black	- Americ k, White,	can Indian, etc.
nours aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Gi	V8		1 Yes	2 X] No	Specify:			Specify:	Whi	.te
LING X IX 13-UU30 be filed within 72 hours after death with the Maryland tial Hygiene. id other than 'natural', or iteme 23a or 28a-f ehow event, the Medical Expriner most be notified at		15. Decedent's E	ducation		16a. Dece	dent's Usua	al Occupa	ation	t of working		16b. Kind of Bus	sines s/Inc	du <i>s</i> try
ithin dithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				10 10	t of working		0001 11	nine	industry
filed w Hygier Sther th		04 17. Father's Name (First, Middle, Las.	.)	-	equip	ment	oper		er's Name (F.		Maiden Sumame		liludely
aryiarre should be f and Mental b marked of umatic eve	To Be	Hill Mullins	,						Sween			,	
re, Marylari s 1 and 2 should be f Health and Mental Item 27 is marked o		19a. Informant's Name/Relationship	(Type, Print)			_					r, City or Town, S		,
71 - 1		John J. Mullins,	Sr. /	son		والمتحدد والمتحدد					Maryland		
Des 1 toth a liter or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 E		State	Place of Dispo cemetery, crea				Date		20c. Location - 0	Dity or To	own, State
Salt Imo beratinent of Department of mportent: If I any injury or o		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Gr	eensbor	2 Name an	d Addro	ce of Equilit	May 16	- Allinovition			, Maryland
DEMILIMOTE, I permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other.		The state of the s	1	1	FI	leegle	and	Hel	fenbei	n Fune	eral Hom	e, P	Α
e N. y.		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that	caused the dea	ith. Do not en	ter the mod	e of dyin	g, such as	cardiac or re	spiratory ar	rest,	039	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	199	65									Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conse			5						
LXaillilei	_	Sequentially list conditions,	F ENS	(or as a conse		RN W	1, 5	1280	220				
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0.1	(0) 43 E 60/136	N C								
ou, be executed icien and burial-transit	Exal	resulting in death) Last	c. ue to	(or as a conse	(to eaneup								
e y se	icai		d										
death certifical death certifical eattending phy defor use as the	Physician/Medi	IF FEMALE:	220 If you o	tooms of progr	22004								
BOX Bath cer attendir for use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregr birth 2 Fet nant at time of	al death 3[□Ectopic pr □ Other (sp					23d. Date Mon		ory Day Year
the dy the control of	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		death of	_ O(()61 (3p	ouny/						
ecords, F.O. law requires that the de as been signed by the i 2 should be detached	by Pł	Part II. Other significant conditions	contributing to c	leath but not re	sulting in the u	inderlying c	ause give	en in Part I		23e. Did to	bacco use contri	bute to th	ne cause of death?
w requires to been signed should be	ted							 		1 🗆 Y	es 2□No :	3 🗌 Prob	pably 4 Unknown
law ri law ri las be	Completed									24a. Was a autop	sy pr	rior to cor	psy findings available mpletion of cause of
VITAI KEC sician: The law certificate has t rrector, page 2 s										perfor		eath?	2 No
OT VICAL Physician: 1 this certifical al director, p	o Be	25. Was case referred to medical examiner? 1 Yes 27 No	Hospital:	Inpatient 2	750/0	-1 20 00	Oth	or	of Death (C	2.00		. (0 (
Phy Phy aral d	H	1 ☐ Yes 2 ☐ No 27. Manner of Death		of Injury oth, Day Year)	28b. Time of		8c. Injun Worl	4 🗆 140			lence 6 Othe		у)
ilon (inding F ath. rr: After re funer	atio	Natural 5 ☐ Pending 2 ☐ Accident investigate	on	nn, Day 16ar)	Injury	м		Yes 2	No				
DIVISION Of VITA Il or Attanding Physicien: after death. I Director: After this certific d in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	288. Plac	e of Injury - At ling, etc. (Spec	home, farm, st	reet, factory	, office		28f.	Location (S City or Tow	Street and Numbern, State)	r or Rura	I Route Number,
Dital o			buildin Tok						4 1				
Hospital 24 hours a Funeral etely filled	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	miner: On the I	e best of my kr basis of examin nner stated.	nowledge, deat nation and/or in	n occurred vestigation	, in my o	ne, date an pinion, dea	ath occurred	at the time, o	cause(s) and man date and place, a	nd due to	tated. the cause(s)
To the Hospital of within 24 hours at To the Funeral D completely filled is	Me	29b. Signature and title of certifier	111			290	c. License	e number			29d. Date signed	(Month,	Day, Year)
		Chain	Maly	ans		H	00	53	775		MAY	12	,2000
		30. Name and address of person wh	completed cau										
a delle see		Faith Jaber, MD 31. Date filed (Month, Day, Year)	32	Registrar's Sign	219 S.	Washi	ngto	n Str	eet I	Easton	, MD 216	501	
St Regist	ate rar	IAA V	32. I)	W A	soll 1							
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ı	Physicia		Decedent's Name (First, Middle, Bernhard Franz								2. Date of De Month May	ath Day	Year 2006		of Death
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			13544 Donnybro		//	In a & fa laste at a		gers	town If Under	24 Hrs	8. Date of Bir	*	Washir	gton	to as Foreign
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20	be filed within 72 hours after deeth with the Maryland all Hyglane. All Hyglane of the than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event. If a Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 🎇 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		an	1 ☐ Yes	2XI No	Specify:				Specify: W	hite	
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Maryland	12 sho		19a. Informant's Name/Relationshi								al Route Numb				
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alti	permit. Peges Department of Important: If I eny Injury or one		21. Signature of Funeral Service Li	censee		2:	2. Name a	nd Addres	ss of Facilit	y Mi	nnich	Funer	al Hom	ie	
m —	80 F 2 9	Ц	23a, Part1, Enter the disease, or c	enli'							Hage		m, Mar	yland	
)	Physician /Medical		shock, or heart failure. List of the limmediate Cause (Final disease or condition resulting in death)	nly one cause on each	line.	quence of):			g, such as	Carulac	or respiratory a			Interval	Between nd Death
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ō	ding Physicien: The In. After this certificete hat	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of In (Month, L		ER/Outpatie 28b. Time o		28c. Injur Wor	4 🗆 140		me 5 Res 28d. Describe			ecify)	
ion	Attending in death.	ation	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation	ition	Jay Year)	Injury	М		k? Yes 2 ☐	No					
Division of Vital	i Di affe	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of	Injury - At h etc. <i>(Speci</i> l	ome, farm, st	reet, facto	ry, office			28f. Location City or To			Rural Route f	/um <i>ber,</i>
	To the Hospital within 24 hours and To the Funeral completely filled	Medical		Physician: To the bes xaminer: On the basis and manner	of examina										se(s)
	ro the vithin if of the comple	Mec	29b. Signature and title of certifier	and manner	Jiaiou.		2	ec. Licens	e number			29d. Dat	e signed (Mor	nth, Day, Yea	r)
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4			30. Name and address of person w	115	, ,	m 23a) (Type	, Print)	Λ	1>	t	<i>(</i> -		M12	1	0 0
S	H-7+1	ate	31. Date filed (Month, Day, Year)	32 R/m	strar's Signa	cl (10	/ ve	496	d	lang	G)	MITTO	run	IND
	Regist		MAY 1 5	2006	Be so	1. 1	parke	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Items 23a, 23pt II 25, 27, 28a - I 8858 8-10-06 vt State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** David Phelps May 3, 2006 9:30A Benson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2703 Red Lion Place 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 F **Funeral** Yrs. 68 215-36-4178 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Waldorf MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2703 Red Lion Place 20602 USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mendal Hygiene important: if item 27 ie marked other than nery injury or other treumatic event, the Mana 2002. Elementary/Secondary (0-12) 12 College (1-4or 5+) Architect Building 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Taylor Johnson Phelps Margaret Emma Phibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Reynolds/Daughter 2703 Red Lion Place, Waldorf, MD 20602

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 5/17/06 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) M00945 ZAREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee Ken 211 ST. MARY'S AVE. LA PLATA MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on the perfect of the cardinal part of t Immediate Cause (Final disease or condition resulting in death) crelerovascula MOR VEO BY MEDICAL EXAMINES **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit CER Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by di secu 1 Yes 2 No 3 Probably 4 XUnknown hip fracture 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 25 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home X Residence 6 Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death T SUNATOral 5 Pending multiple falls unknown M 1 Yes 2 No unknown 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) **UNKNOWN** 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide unknown t<mark>☑ Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 115/56 13251 Baljeet Sethi, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

MAY 16

2006

Book

32. Redistrar's Signature

Waldoc

M.D 20603

06-03145 David Quenton Proctor

Please Type or Print in Black Indelible Ink of Maryland / Department of Health and Mental He

Javid Quenton	1100	1- For State Registrar	Maryland / Depa Ce	ertificate of D		ntai Hygiene	Reg. No. 20	06 1713
Physici Medical Exam		Decedent's Name (First, Middle,Last) David Quent	in I	Proctor	Tr	2. Date of E	Day Year	3. Time of Death 2026 hrs
		4a. Facility Name (if not institution, give str			City, Town, or Location	May 9,	4c. County of De	
		6200 Hellen Lee Drive			linton		Prince Geor	-
Funeral Director		5. Social Security Number 6. Sex 215-74-2590 1X M	7. Age (In yrs. 2 F 35		Under 1 Year If Un Months Days Hou	rs Min		eign
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ow any		10a. State 10b. County		y, Town or Location				10d. Inside City Limits
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ours aft ntural" amine	d by	15. Decedent's Education (Specify only h	Dates:	16a. Decedent's l	s 2 X No specification (Given	kind of work done	Specify: D	
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e, MD and 2 shc Health and item 27 is		Phyllis Proctor 20a. Method of Disposition		Place of Disposition	(Name of cemetery,	St.Apt.3	Oxon Hill 20c. Location - City	1 MD 20745 or Town, State
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Saltii rmit. I epartm nporta jury o		21. Signature of Funeral Service Licensee				tyAdams Fu	neral Home	, Har yrand
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Physician — /Medical		failure. List only one cause on each li	shot of head	i. Do not enter the n	ode or dying, such as	cardiac or respiratory	arrest, snock, or neart	Approximate Interval Between Onset and Death
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ivis lor At after d Direct	tific	3 Suicide 6 Could not be	28e. Place of Injury - At h		ctory, office building, e	tc. 28f. Location or Town	(Street and Number or R	ural Route Number, City
Ospital hours uneral ly fillec		4 Homicide determined 29a. Certifier	(Specify) Home			6200 Helle	en Lee Drive, Clinto	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On	To the best of my knowled the basis of examination a	and/or investigation,	at the time, date and pi in my opinion, death o	ace, and due to the ca ccurred at the time, da	use(s) and manner as sta te and place, and due to t	rted. he cause(s)
7 × 5 0	Me	29b. Signature and title of certifier	manner stated		29c. License number		29d. Date signed (Me	onth, Day, Year)
		Theodore Me)	678m	Ω	O.C.M.E.		May 10, 2006	
SRG		30. Name and address of person who comp Theodore King MD. Assista	leted cays of death (Item nt Medical Examine		Street, Baltimore	MD 21201	•	
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			For State Registrar		State of M	1 arylan		artmen rtificate					Reg. No.	06	1	39
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ı	Examin	er			e street and number						oi Death			•		
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	and		Usual Residence of 10a. State	Decedent 10b. County	-	10c. Cit	y, Town or Lo	ocation							10d. Inside City Li	imits.
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Ball	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or othar once.		21. Signature of Fu	neral Service Lice	nse	9	F		S, HE	LFENI	BEIN	& NEWNA			OME, P.A	L •
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)		nysician: To the bes miner: On the basis and manner:	of examina										
	To the Howithin 24 To the Formplete	Me	29b. Signature and	title of certifier	^			29c	License	number			29d. Date sign	ed (Month,	Day, Year)	
			111	UNAI	W			N	MJ.	1896	22		5/1/	04		
			30. Name and addre	ess of person who	comp ed cause of	death (Iten	n 23a) (Type,	-		The Table			1	- 10		
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	State AMERIC LUCIL Registrar	State of Maryla 24a per verb	.,G85/ _{ei}	9716954969	beath	Reg	g. No.) 0 1 1 1 57		
	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month		3. Time of Death		
	WILLIS KEITH	PALM	ÆR			MAY 3	200			
						Death EN ANNE				
	5. Social Security Number 6. Se	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	-	Birthplace (State or Fore Country)		
	213-09-1615	X ^M ² □ F 90	Yrs.	Months Days	Tiodis Will.			PENNSYLVANI		
) i-	10a. State 10b. County	10c. C	City, Town or Lo	cation		**		10d. Inside City Lim		
tō	MD QUEEN	ANNE	CENTREV	/ILLE				1 ☐ Yes 2 1 ☐		
lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?		
	171 WIND DRIFT I	ANE		2	1617		USA			
neu	11. Marital Status	Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc.		
Y.	1 Never Married 2 Marned	If Yes, Give		I∐Yes 2¶ No	Specify:		Specify:	WHITE		
ed b			16a, Dece	lent's Usual Occupa	ation	11	6b. Kind of Busi	ness/Industry		
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E O	12	1	SI		BETHLEHEM ST					
	17. Father's Name (First, Middle, Last)						,			
To	ESROM LANDIS PALM	IER			MA	KGARET KE	11H			
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			and the same		T LANE,					
	1 Burial 2 XCremation 3	Removal from State CHI			ÖN	- 1	DC. LOCATION - C	ny or rown, state		
		CI	ENTER, I	LLC	5-6-	2006	STEVE	NSVILLE, MD		
	21. Signatura of Full Plan Service Little	1000	FF	ELLOWS HE	LFENBEIN	& NEWNAM CENTREV	FUNERAT	L HOME, P.A D 21617		
al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. /wsfach		y Dusc ancer	cust.					
0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 [Other (specify)		220 Did toba	23d. Date Monti	n Day Year		
þ	Part II. Other significant conditions of	1 Yes 2 No								
Complete							opsy prior to completion of cause death?			
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lon	1 ☐Natural 5 ☐ Pending	(Month, Day Year) Injury Work?						ury occurred		
ertifica	2 () 100100111	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location		on (Street and Number or Rural Route Numb r Town, State)			
	(Check only 2 Medical Exam	niner: On the basis of exami-								
Mec	29b. Signature and title of certifier	0/		29c. License	e number	296	d. Date signed (Month, Day, Year)		
	- 111 .	1 1								
	> Valene	mami	_	4005	7821	(5/3/0	6		
	30. Name and address of person who	completed cause of death (It	em 23a) (Type.	29c. License + HOOS Print) VACER	7821	nan	5/3/0	6		
	o Be Completed by Physician/Medical Examiner	WILLIS KEITH 4a. Facility Name (If not institution, gives 171 WIND DRIFT LA 5. Social Security Number 6. Security Number 10a. State 10b. County MD QUEEN 10a. State 10b. County MD QUEEN 10a. Street and Number 171 WIND DRIFT I 11. Marital Status 1 Dever Married 2 Marned 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) 15. Decedent's Ed (Specify only highest grave) 16. Security Numbers 172 Marned 18. Informant's Name/Relationship (I	WILLIS KEITH 4a. Facility Name (If not institution, give street and number) 171 WIND DRIFT LANE 5. Social Security Number 213-09-1615 Usuel Residence of Decedent 10a. State 10b. County MD QUEEN ANNE 11. Marital Status 11. Merital Status 11. Merver Married 21. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 12. 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Secular Name (if not instatutor, give street and number) 171 WIND DRIFT LANE 5. Social Security Number 213-09-1615 5. Social Security Number 213-09-1615 10. Cly, Town or Location of Death MARCH 28 Users Residence of Deadeding Winding Days Hours Min. (Action of Days) March 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 Users Residence of Deadeding MARCH 28 100. Street and Number 171 WIND DRIFT LANE 172 Was Deader's Palmanic Crizin's (Specify Yes or No-1) (Proposed Specify Language Control Contro	WILLIS KETTH PALMER 40. City, Town, or Location of Death ACT 3 200 40. City, Town, or Location of Death ACT 3 200 40. City, Town, or Location of Death ACT 3 200 40. 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State of Maryland / Department of Health and Mental Hygiene 1 6 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician MAY 13. 2006 1:10 A M JOYCE ANN PALMER-MEADOWS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 04-11-1945) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**%** F Yrs 578-58-4058 Wash..D.C. Director 61 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be notified at 1 to Yes 2 □ No Directo Maryland Prince George's District Heights 10e. Street and Number 10g. Citizen of What Country? 6115 Alpine Street 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after de tal Hygiene. d other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 2 No Specify: þ 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\stackrel{\text{Elementary/Secondary (0-12)}}{12\text{th}}$ College (1-4or 5+) Nurse Private or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: If item 27 le marked other Charles William Palmer Ada Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Venus Twana Haywood/daughter 10405B 46th Ave. #B102 Beltsville, Md. 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Wash.Nat'l Cemetery 05-19-2006 Suitland, Maryland 4 Donation Other (Specify) 21. Signat a of Fur eral Service Licensee 22. Name and Address of Facility Cedar Hill FH Inc. 4111 Penn., Ave. Suitland, Md. -mo 145 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MY OCARDIAR INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed CEREBRO VASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 RVOutpatient 3 DOA Certification: To 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000 pil D40324 MAY 15, 2006 dress of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MARYLAND 20735 TERRY JODRIE, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State MAY 1 8 2006 Registrar

			For State Registrar	State of Mary		epartment <i>Certificate</i>				iene 200	6 17142		
	Physicia		1. Decedent's Name (First, Middle, Las		D				2. Date of Deat Month	th Day Yea	3. Time of Death		
	Physicia /Medic	al	Marvin 4a. Facility Name (If not institution, give	Maurice	Pratt		Town or Loca	ation of Death	May 16	4c. County of De	8:45 A ^M		
	Examin	er	704 Routzahn	erals			Caroli						
	Funeral Director		213-42-0203	ex ☑M 2☐F	hday) If Under Months		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 10/12/	(Year) 9. E	lirthplace (State or Foreign Country) aryland			
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10	Dc. City, Town	or Location					10d. Inside City Limits		
	a-f eh	ctor	MD Caroline Federalsburg								1 ☐ Yes 2 ☐ No		
	death with the Maryland ims 23s or 28a-f ehow Fittes Les polities at	Director	10e. Street and Number	T		10f. Zip		0		0g. Citizen of What	•		
	eath v	Funeral	704 Routzahn	Lane 12. Was Decedent Eve	r in U.S.	13. Was Deced	2163			Jnited S	tates nerican Indian,		
_	be filed within 72 hours after death with the Marylar lat hygiene d other than "naturel", or Itams 23s or 28s-f show event, the Masical Examinat mai be putified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □XYes 2 □ No	53-69	13. Was Deced If Yes, spec		ecify:	Rican, etc.)	Black, W			
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7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Μe	ine DONOTus chanic	e retired)			Tire Co	mpanv		
ב ב	uld be filed v Aental Hygie rked other i tlc event, E	Be Co	17. Father's Name (First, Middle, Last)				18.	Mother's Name	(First, Middle, I	Maiden Sumame)	p y		
yland	should be and Menta marked umatic ev	ToB	Harding R. Pr		-					rawberr			
Man	2 short and le mark	1	19a. Informant's Name/Relationship		1	_				r, City or Town, State			
	as 1 and 2 should b of Health and Ment I Itam 27 ie marked r other traumatic e		Elaine Hubbar 20a. Method of Disposition	The second secon		Disposition (Namer, crematory or of				Lsburg, 1			
Baltimore,	Page ent nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	y)		al Hil	1 Cem				burg, MD		
g	permit. Departm Importa eny inju		+ Roloule_			216 N.	Main	St., Fe	mptom deralsb	Funeral ourg, MD 2	Home, P.A. 1632		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
ì	Physician		Immediate Cause (Final disease or condition resulting in death)			rdial I					Onset and Death acute		
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P.O. Box	requires that the death certifi een signed by the attending hould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			23d. Date of o Month	delivery Day Year						
	s that pred b	y Pt	Part II. Other significant conditions of		Part I.	23e. Did tol	bacco use contribute	co use contribute to the cause of death?					
g	w requires been signe should be	ted	Prostatic Car	ncer					1 🗆 Y	es 2 □ No 3 □	Probably 4 Nunknown		
Division of Vital Records,	The law ate has b page 2 s	Completed by							24a. Was a autops perform	med? death	autopsy findings available o completion of cause of ? es 2 \square No		
<u> </u>	Phyeician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	2 🗆 EB/Out	patient 3 DO	Other		(Check only on	ence 6 Other (S	and i		
on of	ding h. After fune	tion; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y			8c. Injury at Work?	2		ow injury occurred	эвспу)		
DIVIS	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After i completely filled in by the funera	Certification;	3 Suicide 6 Could not b 4 Homicide determined		- At home, far Specify)	home farm street factory office 28f. Location (St.					Street and Number or Rural Route Number, m, State)		
	To the Hoepital or A within 24 hours after To the Funeral Direction plately filled in by	Medical (nysician: To the best of n niner: On the basis of ex and manner stated	amination and								
	withi To the	Σ	29b. Signature and title of certifier	ROMANIA	40		. License nun			9d. Date signed (Mo			
ļ			Curvillan)	Zewell M	10	D	1466	4		May 17,	2006		
			30. Name and address of person who C.E. Jensen,	completed cause of deat MD Deputy			690,	Dento	n, MD	21629			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's		Prost							

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		1 - Stete Registrer			rtificate of L			Reg. No.	1/140
Physic		Decedent's Name (First, Middle, Last) GEORGE MAC ARTHUR I	RTI.EY				2. Date of De Month Ma.v	Day Year 14 2006	3. Time of Death 5:40 p
/Medi Exami		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Dea	
		CIVISTA MEDICAL C. 5. Social Security Number 6. Sex		e (In yrs. last birthday)	LaPlata,	Md If Under 24 Hrs.	8. Date of Bir	Charles 9. Bir	thplace (State or Foreign
Funeral Director		215-70-9059	M 2□F	49 Yrs.	Months Days	Hours Min.	DECEMBE!		RYLAND
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
th the Marylar or 288-1 show	ctor	MARYLAND CHARLES		WHITE PLA					1 X Yes 2 □ No
Riley death with the Maryland ms 23s or 28s-1 show trought at	I Dire	10e. Street and Number 9922 RHODES WAY			10f. Zip Code 20695	;		10g. Citizen of What C	·
ter death	inera		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I	cify Yes or No Rican, etc.)	14. Race - Am Black, Whi	
~ 9 to 5 E	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 1 If Yes, Give Year or Dates:	No.	1 ☐ Yes 2 🗓 No	Specify:		0 "	ACK
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ind 2	BeC	17. Father's Name (First, Middle, Last)	DV			18. Mother's Name		, Maiden Sumame)	
Maryland Maryland d 2 should be file the and Mental Hy 77 is marked out traumatic even	10	GEORGE VINCENT RILL 19a. Informant's Name/Relationship (Typ.		19h Maili				OPER LYLES oer, City or Town, State,	Zip Code)
Ma alth an 127 is:		PATRICIA A. LYLES	_		-	COURT, WAL			0602
Baltimore, M. semil. Pages 1 and 2 Separtment of Health a mportent: If tem 27 is any bright or other transmen.		20a. Method of Disposition 1 28urial 2 Cremation 3 Re	emoval from State		matory or other plac	(e)	ate	20c. Location - City or	
Baltimori permit. Pages Department of P Importent: If ite eny Injury or of		4 Donation 5 Other (Specify) 21. 3 nature of Funeral Service Livense	e 4 -7.1	ST. CATHERI	2. Name and Address	ss of Facility		MC CONCHIE,	, MARYLAND
Balti permit. Departr Importe eny Inji		LYDIA C. THORNION JO	HNSON MOOS	200		VERAL HOME, TON ROAD, IN		AD, MARYLAND	20640
		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused ne cause on each li	the death. Do not en	ter the mode of dyin	g, such as cardiac o	r respiratory a	arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence of):	rary c	an tery	au	sease	
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rted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
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6876 tificate bu ig physici as the bu	dlcal	_ d	l						
Box 687(leath certificate to ettending physic	in/Me	23b. Was decedent pregnant	3c. If yes, outcome		□Ectopic pregnancy	,		23d. Date of de	,
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
;, P.O. I s that the de ned by the e	by Ph	Part II. Other significant conditions con	ntributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
of Vital Records, Physicien: The law requires termis certificate has been signeral director, page 2 should be de-		1					10	Yes 2 No 3 P	robably 4 Unknown
Reco	Completed						24a. Was auto perfe	prior to death?	utopsy findings available completion of cause of
Vital Ro	Be Co	25. Was case referred to medical		- 3.		26. Place of Death	1 Yes	2 → No 1 □ Ye	s 210 Mo
of Vi hysici his cer Li direci	To B	1 105 210110	lospital: 1 🗌 Inpatio					idence 6 Other (Spe	ecify)
on of ding Ph. After th. funeral	tlon:	27. Manuar of Death 1 VNatural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time (Injury	Worl	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
Division If or Attending after death. I Director: Afte	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st	treet, factory, office		28f. Location ((Street and Number or Fi	ural Route Number,
Dj pital or nus afti erel Dii	O		1		th account at the fire	ma data and place	and due to the		
Divi	edical			of examination and/or in				cause(s) and manner a , date and place, and du	
To the within To the comp	M	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mon	
		30. Name and address of person who co	>	doath (Itom 32a) /T	D 457	737		5/16/0	<i>b</i>
DB 2		JAYANTHAN, NIRMALA	ADEVI, MD	. 3328 OLD	WASHINGT	ON ROAD W	aldorf,	, MD. 2060	2
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	Ana N. a				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar	yland /		rtment of H		Mental H	ygier Reg. I	74 U U	6	1711	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of I Month			/ear	3. Time of Death	
	/Medic	al	ROBERT MARK ROBIN 4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of Da	MAY	11	2006 4c. County of		07:05 A M	
	Examin	er	21319 INDIANA AVE				ERTOWN	401		KENT	Dodai			
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		Birth Day, Yea / 194		9. Birthp Court	lace (State or Foreign try) MD	
	pu »		Usual Residence of Decedent 10a. State 10b. County		IOc. City, To	num or Lo	nation					1	0d. Inside City Limits	
	Aaryla r shor	ō	MD KENT		CHES'								1 ☐ Yes 2 No	
	28a-	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of Wh	nat Coun	try?	
	h with	ai Di	21319 INDIANA AVE				21620				USA			
36	be filed within 72 hours after death with the Maryland tal Hygiene d other then "neturel", or items 23e or 28a-f show event, the Medical Evanting must be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give		lt lt	Vas Decedent of Hi Yes, specify Cuba □ Yes 2 No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or I erto Rican, etc.)	No-	14. Race Black, Specify:	Americ White,	etc.	
Ö	turel'		15. Decedent's Educ	Year or Dates:	16	Sa. Deced	ent's Usual Occupa	ation		16b.	Kind of Bus	iness/Ind	dustry	
21215	filed within 72 Hygiene. other then "nei ent, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)						rorking		ING			
Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last) TIIT TAN THOMAC DOBINGON							e (First, Middle, Maiden Surname) ETHEL KUHN				
	12 sh and is m		19a. Informant's Name/Relationship (<i>Ty</i> , MICHAEL CONSTANTIN	_	N AVE., FORK, MD21051					Code)				
altimore,	Pages 1 and 2 nent of Health int: if item 27 inty or other tre		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	ceme	ace of Disposition (Name of Date 20c. Location metery, crematory or other place) LL POND CEMETERY 05/16/2006 STILL						ion - City or Town, State		
Balti	permit. Pages 1 and Department of Health importent: if item 27 eny injury or other t		21. Signature of Funeral Service License	Name and Address	s of Facility HELFENB ROAD,	EIEsAER1	NEW	NAM FU	NEB l	L HOME				
	Physician	y Uk	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the cause on each line			er the mode of dyin	g, such as cardi	ac or respiratory				Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to or as a	consequenc	ce of):	2712					12 mo.		
	xecuted n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								7 da		7 day	
68760	ficate be executed g physician and as the burial-transit	edicai		j										
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	luires that n signed b ild be deta	ρ	ρ	1	ntributing to death but	but not resulting in the underlying cause given in Part I.					24a. Was an autopsy findings available prior to completion of cause death?		\ .	
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ita		Be C	25. Was case referred to medical examiner?		26. Place of Death									
	Physicien: r this certific ral director,	To	1 Tes 2 No	lospital: 1 ☐ Inpatient		Outpatien		4 🔲 Nursing	Home				"	
Division of	Attending P ir death. ector: After t by the funera	atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		o. Time of Injury	28c. Injun Worl M 1 []	y at 28d. Descrit e how injury occurred k? Yes 2 □ No						
Divis	or afte Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined		28f. Location City or 7	(Street own, St	and Number ate)	or Rura	l Route Number,					
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical		sician: To the best of ner: On the basis of e and manner state	xamination									
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}	~		100				1 705	1735			5)121	06		
3)	,	30. Name an address of person who co	ompleted cause of dea	ath (Item 23a	a) (Type,		Abost	ertour	, r	- din	11/	20	
	m_S Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	uch	IIII Ka	CUCZI	1000x	11 1	1y o	L 160	3O	
	Regist		MAY 10	2006		A-2	Ann. M.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** nardi 3:55 PM 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death street and number. Examiner MD Baltinare Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. 10/16/1908 6. Se 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 XM 2 □ F 341-05-2903 97 MD Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count or 28a-f ehov the Medical Examiner must be notified at 1 X Yes 2 ☐ No MD CHESTERTOWN KENT Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25820 COLLINS AVE. 21620 USA 238 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Maryland 21215-0036 marked other than "natural", or Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MECHANICAL ENGINEER STEEL FOUNDRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Heath and Mental H ant: If Item 27 is marked out HENRY B. REINHALDT, SR. HELEN JANE OGIER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES REINHARDT/SON 290 CALEF HIGHWAY, #D25, EPPING, NH 03042 or other Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State permit. Page Department (Important: #f eny injury or CHESAPEAKE CREMATORY 05/22/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ÎÊLFÊNBEIN ADN NEWNAM FUNERAL HOME ROAD, CHESTERTOWN, MD 21620 Duk (23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) ANA ANA Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown certificate hes been si rector, page 2 should i Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 Yes Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injuly occurred After 1 Natural 5 Pending 1 🗌 Yes s after death. 2 Accident investigation 12:00 the 6 Could not be determined 3 Suicide Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office in by 1 O COLUNS AVE 4 - Homicide HOM , marylana Hospital filled within 24 hours of the Funeral 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature an title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fames MA cency

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 2 2006

32. Register Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2006 Physician Month Mary J. Randall May 12, 8:21 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**) F 230-20-8388 86 Director 25, 1919 VA Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show r than "naturel", or itema 23a or 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Prince Georges Suitland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3940 Bexley Place #218 20746 Funeral S. A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Vendor Food Service permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: if item 27 is marked other any injury or other traumer: traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mose Halev Agnes Wanzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Ferguson - sister - inlaw 1711 Girard Street, NE Washington, DC 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ouantico National Cem. 5/23/06 Quantico, VA 22. Name and Address of Facility Bell and Johnson Funeral Home Pro 21. Signatur of Funeral Service 6503 Old Branch Ave., Temple Hills, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examiner or Attanding Physician: The law requires that the death certiticate be executed for use as the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) 0.0 tha 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ate has been signi page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No Be 25. Was case referred to medicat examiner? 26. Place of Death Check only one Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dev. rei Director: After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerei L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature a d title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and a 10403 Hospital Drive, Suite G-06 Clinton, MD 20735 31. Date filed (Month, Day, Year) State MAY 1 7 2006 Registrar

			For State Registrar	State of M		d / Depa		t of H	ealth a			giene	_	1711,7
			Registrar 1. Decedent's Name (First, Middle,	l aet)			incare	JUIL	Jean		2. Date of De	Reg. No.		3. Time of Death
4	Physici	_		, Last)	(MINNIC	K				Month	Day	2006	1. 21.
	/Medic	al	WICKLIFE 4a. Facility Name (If not institution,	aire atreet and number		771		Town or	Location of	of Death	MAY	14	County of De	
	Examin	er	BLAKEHULST	give street and number	,			wso~) Douti			AZTIMU	
			5. Social Security Number	6. Sex 7. A	ae (In vrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bir	†h		irthplace (State or Foreign Country)
12	Funeral Director		579-10-9159 Usual Residence of Decedent	1□M 2(X)F	86	Yrs.	Months	Days	Hours	Min.	Sept.	ly, Year)	919 Ke	ntucky
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. fnside City Limits
	Many Hind	to	Maryland Balti	more	Т	owson								1X☐Yes 2☐No
	the 28s	Director	10e. Street and Number	mor e	•	0113011	10f. Zip	Code				10g. Citiz	en of What C	Country?
	3a of		1055 West Jopp	a Road				2120	14				US	
	ms 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.))- 1	4. Race - Arr	nerican Indian,
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nd	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or items 23a or 28a-1 show other than "natural", or items 23a or 28a-1 show event, the Macilcal Exactinational tenditied at	Be	17. Father's Name (First, Middle, I								(First, Middle			
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Baltimore, Maryland 21215-0036	permit. Pages 1 as Department of Hea Important: if item any injury or otha		21. Signature of Funeral Service I	di	M013	H		Fune	eral H	Home	P. 0.	Box	lashing 156, k	gton Rd.20604 Maldorf, MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) 2006 Year MAY Month Physician 10 1530 PM **FDWARD** SPINDLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON MEMORIAL HOSPITAL AT EASTON If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 6. Sex 5. Social Security Number **Funeral** 1 MM 2 □ F 1930 WASHINGTON, DC AUG. 75 579-44-5594 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County worle in than "natural, or items 23a or 28a-f ehover the Medical Examination routined at 1 ☐ Yes 2 No CENTREVILLE QUEEN ANNE MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21617 TISA 209 HOPE ROAD Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1951–1955 11. Marital Status a filed within 72 hours after if Hygiene. 1 Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT AIRCRAFT MECHANIC 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY MARGARET ROCHE EDWARD H. SPINDLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at important: if item 27 is any injury or other trau 209 HOPE ROAD, CENTREVILLE, MD 21617 SHIRLEY A. KOTZ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State PETER'S CATHOLIC 5-16-2006 QUEENSTOWN, MD * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part: Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed buriaj-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown is been signed by the 2 should be detached 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ₺Unknown PELLIDIDEMIA 1 ☐ Yes 2 ☐ No Be Completed Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page 2 vasular Peripheral 1 ☐ Yes 2 🔀 No certificate Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No hours after death. Ineral Director: A investigation 2 Accident the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number PHISICIAN 29b. Signature and title of certifier ē 11/2006 40057821 ·D.0

State Registrar

DHMH 17 Rev 1/2001

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Centreville

30. Name and address of person who

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

empleted cause of death (Item 23a) (Type, Print) Doud

Valerie Good mAn.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 📗 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:01 PM Anthony 4. 05 10 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Batt more University of Maryland
5. Social Security Number 6. Sex Shock Town Center N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, Sept. 1). 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1987 X M 2□F Maryland 18 Yrs. 219-15-4423 Director Maryland Anne Arundel
10b. County
Anne Arundel
10c. Street and Number
319 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or theme 23a or 28a-f show amy injury or other traumatic event, the Mardical Exercities invest be rediffied at once. 1 ☐ Yes 2\(\)\(\)\(\)\(\) Baltimore 10g. Citizen of What Country? 10f. Zip Code 319 Berlin Ave 21224 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 XNever Married 2 Married ☐Yes 2 Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes XXNo Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Restaurant 9th 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Chesterfield Sharps Jr. Mary Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md. 21224 Mary Poole(Mother) 319 Berlin Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 5-15-06 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. 12, Teese M00483 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complications Neck **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, CERTIFICATION APPROVED BY MEDICAL EXAMINER Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown cate has been signed , page 2 should be del 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🗷 🗘 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has, autopsy perform 2 No this certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred Subject Manner of Death 28b. Time of Injury 28c. Injury at Work? After Natural 5 Pending 12:37 P dove into 1 ☐ Yes 2 XNo within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 3 ☐ Suicide Shallow water investigation 05/04/2006 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) | 3| Le Rivd + 4 Homicide Birda Cedarwood in Beach CrownsvilleML Hospital 182 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) the

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person-

31. Date filed (Month, Day, Year)

Felix

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3+

no completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

S. Green

22

29c. License number

Baltimore

L16535

29d. Date signed (Month, Day, Year)

May

10, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

		1 - For State Registrar		artment of Health and Natificate of Death	fental Hygien Reg. N	1.000 11101
Physi /Med		Decedent's Name (First, Middle, Last) Eugene Paul	_ Sw	ift	2. Date of Death Month D May 1	ay Year 3. Time of Death 4:45 p M
Exam Funera Directo	iner	4a. Facility Name (If not institution, give street and 1838 Generals Highway 5. Social Security Number 539-09-8115 6. Sex 1 ☒ M 2 ☐ F	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Anne Arundel 9. Birthplace (State or Foreign Country) Washington
and 21215-0036 be filed within 72 hours after deeth with the Maryland tlat Hygiene. ed other than "naturel; or items 23a or 28a-1 show event, the Madical Examinat must be incitified at	Completed by Funeral Director	1 Never Married 2 Married 1 X Ye 3 X Widowed 4 Divorced Year o	s 2 □ No Give r Dates: WWII	S 10f. Zip Code 21401 Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	10d. Inside City Limits 1 □ Yes 2 ☒ No itizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White
ind 2121 be filed within tat Hygiene. d other than "	To Be Complete	17. Father's Name (First, Middle, Last) Alfred Levinus Swift	e (1-4or 5+) Ships	Lucy	e (First, Middle, Maide Bradshaw	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: it tem 27 is marke any injury or other traumatic		19a. Informant's Name/Relationship (Type, Print) Patricia E. Swift (Dat 20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	nghter) 1838 20b. Place of Dispo cemetery, cren Metro Cre	natory or other place)	, Annapoli Date 200. 8 /2006 Ba Home, P.A.	s, MD 21401 Location - City or Town, State 1timore, MD
Box 68760, eath certificate be executed extra control of the con	1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	at caused the death. Do not ent n each line. MANUSERVA to (or as a consequence of): Con as a consequence of): to (or as a consequence of):			Approximate Interval Between Onset and Death
O st affile	Physician/Med	250. Was deceded pregnant 1 □ Liv in the past 12 months? 1 □ Ves 2 ™ No 4 □ Pro		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
I Records, F The law requires thate has been signed page 2 should be de	Completed by Ph	Part II. Other significant conditions contributing to	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	24b. Were autopsy findings available prior to completion of cause of death?
on of Vita ding Phyeiclan: After this certific funeral director,	ertification; To Be C	27. Manner of Death 1 ANatural 5 Pending (No. 2 Accident investigation	□ Inpatient 2 □ ER/Outpatien te of Injury onth, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 Nursing Ho	h Check only one ome 5 S Residence 28d. Describe how inj	
e aging c	O	4 Homicide bu	ace of Injury - At home, farm, strilding, etc. (Specify) the best of my knowledge, death	n occurred at the time, date and place,	City or Town, Sta	s) and manner as stated.
To the Hospital Within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the and m	red at the time, date ar	ate signed (Month, Day, Year) 05/12/2006 King Lee		
Regi	State strar	31. Date filed (Month, Day, Year) MAY 1 5 2006	Registrar's Signature	1 2140		

		1 - For Amend #24ac	State of	Marylan 19	d /8 702 Cei	rtment of tificate of	Health a Death		giene Reg. No. 20	06 1715		
Physicia /Medica	ın	1. Decedent's Name (First, Middle, Last 70SEPH	524	MAN	ISK!			2. Date of De Month		Year 70 3. Time of Death		
Examine	er	4a. Facility Name (If not institution, give University of Mo 5. Social Security Number 6. S	uyland			4b. City, Town, Ball If Under 1 Year	Kino	u, Mi)	4c. County o	1A		
Funeral Director			MM 2016	51	Yrs.	Months Days		Min. (Month, Da	iy, Year) +, 1954	9. Birthplace (State or Fore County) Pennsylvania		
e Maryland Ba-f ahow	Director	Delaware Kent			ver					10d. Inside City Limi 1 X Yes 2 □ N		
th with th	al Dire	10e. Street and Number 161 Pine Cone Dr	ive			10f. Zip Code 19901	L		10g. Citizen of W United	hat Country? States		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic avent. The Medical Examinar must be notified at once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	ss? M∑No		Was Decedent of f Yes, specify Cu	ban, Mexican	in? (Specify Yes or No , Puerto Rican, etc.)		American Indian, K, White, etc. White		
within 72 ho ene. then "natur he Medical	ompleted	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	e durina most	of working	16b. Kind of Bus			
uld be filed Mental Hygi arked other atlc avent.	12 Clerk Supermar To seph Szymanski 19a. Informant's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, A.											
nd 2 sho alth and 1 27 le ma r treuma				Wife								
Pages 1 a ent of Hee nt: If item ry or othe	Lois A. Szymanski/Former Wife 161 Pine Cone Drive, Dover, Delaware 199 20a. Method of Disposition 1											
permit. Popartm Importar any inju		21. Signatule of Funeral Service Licer		aryland 21921								
ate be nysicie he bui	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or b. Due to (or c.	as a consequence as a c	ience of):	neumo	thore	<i>y</i>		Onset and Death		
death certiti e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal tat time of de	death 3[Ectopic pregnant	су		23d. Date Mont	of delivery th Day Year		
w requires that the been signed by th should be detache	ed by Pr	Part II. Other significant conditions of	ontributing to deal	h but not resu	ulting in the u	nderlying cause g	iven in Part I.			bute to the cause of death?		
The law ate has b page 2 sł	Completed by	Sepsis					24a. Was autop perfo	osy pr irmed? de	ere autopsy findings availa for to completion of cause eath? □ Yes 2XXNo			
9 9 9	25. Was case referred to medical example?					thor	of Death Check only of Sing Home 5 ☐ Resident	-115	r (Specify)			
fre fre	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Day Year)	28b. Time of Injury	M 1[Yes 2 N	10	now injury occurre	d r or Rural Route Number,		
	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as (Check only								ner as stated.			
To the within 2. To the complet.	Medi	29b. Signature and title of certifier	and manner	stated.	m	29c. Licer	774		29d Date signed	(Month Day Year)		
6		30. Name and address of person who	completed fuse	f death (Item	23а) (Туре,	Dept.	1 5	I Surge	y Ba	12006 Uthure M2		
Stat Registra		MAY 17 2006 Heaves A Charles										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🗎 🗎 🦰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 16, GERALDINE ELAINE SULLIVAN May 5:45 p /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2009 Sheridan Street Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🕅 F 73 1932 Director 214-30-4249 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County id other than "natural", or items 23a or 28a-f ahow evant, the Medical Examer must be notified at 1X Yes 2 No Prince George's **Hyattsville** Maryland Direct 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2009 Sheridan Street 20782 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 M Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 11 Homemaker Own Home 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic evan Be Irvin G. Herman Mary Ellen Paul ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2009 Sheridan Street, Hyattsville, 110 20782 Joseph Sullivan, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1
☐ Burial 2
☐ Cremation 3
☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/19/2006 Brentwood, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Coronary Artery Disease /Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus II Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit Hypertension that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 5 Other (specify) detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 8 1 X Yes 2 □ No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Injury 5 Pendina 1 X Natural 1 ☐ Yes 2 ☐ No М investigation in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide completely filled 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

the Maryland

within 72 hours after death

certificate be executed

Box 68760.

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Records,

Division of Vital

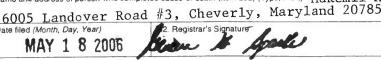
Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State MAY 1 8 2006 Registrar

29b. Signatur

title of certifier

m. Shalella



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukemil Abdella, M.D.

DHMH 17 Rev 1/2001

29c. License number

18492000

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryland		artment rtificate			nd M	lental Hy	giene 2 { Reg. No.	06	1715
			Decedent's Name (First, Middle, Last	(t)							2. Date of De			3. Time of Death
	Physici		Bonita Jean SNYDI	ER							Month	Day 15 2	Year O O G	15:45 M
i	/Medic Examir		4a. Facility Name (If not institution, give	street and numb	er)		4b. City. T	own, or	Location of	Death	or two		y of Death	7-2-75
d.	CXAIIII	iei	Washington County	Hospita	a1				ersto				hingt	on
	Funeral		5 Social Security Number 6 Se	ex 7.	Age (In yrs. la	st birthday)	If Under 1	Year	If Under 2	4 Hrs.	8. Date of Birt	h	9. Birtho	place (State or Foreign
	Director		283-26-0618	□M 2ĂF	75	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept. 30	y, Year) 3,1930	Ohi	
	σ		Usual Residence of Decedent											
	nylan how	_	10a. State 10b. County		10c. City,	Town or Lo							1	10d. Inside City Limits
	8a-f	cto	Maryland Washir	ngton		Hag	erstow	m						1 ☐ Yes 2X No
	or 24	Olre	10e. Street and Number				10f. Zip C					10g. Citizen of	What Cour	ntry?
	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "natural", or itema 23a or 28a-f ehow event, the Medical Examinar must be notified at	Funeral Director	11150 Robinwood I				2	174	2			USA		
	ter dea Itema	nue	11. Marital Status	12. Was Decede Armed Force	es?		Was Decede If Yes, specif	int of Hi y Cubai	spanic Orig n, Mexican,	in? (Spe Puerto	ecify Yes or No Rican, etc.)		ce - Americack, White,	
36	or l		1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	_		1 ☐ Yes 2	⊠ No	Specify:			Speci	ர்: wh:	ite
21215-0036	hour tural	Completed by	3 ☑ Widowed 4 □ Divorced	Year or Date	es:	16a D	danda Harrat	0						
5	c * 6	lete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual kind of work DO NOT use	done d	urina most	of worki	ing	16b. Kind of E	ousiness/in	austry
12	within ene. then "	E C	Elementary/Secondary (0-12)	College (1-4	or 5+)	_	emaker					her	own h	ome
9	should be filed withing Mental Hygiene. marked other then mattic event, the M	Ö	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle,			
an	Mental Mental arked o	To B	Charles Quincy Ad	lams					Bes	sie	White			
Maryland	2 should I and Meni Ie marke aumatic	۳	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailie	na Address (Street a	nd Number	or Rura	al Route Numbe	er. City or Town	. State. Zic	(Code)
Σ	id 2 in all lith ar		Linda Folmer - da								agersto	•		•
ā	s 1 and 2 should of Health and Mer Item 27 le marke other traumatic		20a. Method of Disposition		20b. Pia	ace of Dispo	sition (Name	e of			ate	20c. Location		
Baltimore,			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				natory or oth			av 1	9, 2006	Duncan	Fa11	s Ohio
₽	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service Licen				. Name and				INNICH			
Ba	permit. I Depertm Importar eny inju		11.000	0:		1				1.1	, Hager			21740
			23a. Part1. Enter the disease, or comp	olications that cau	sed the death.			-					rid. 2	Approximate
1	D		shock, or heart failure. List only immediate Cause (Final	one cause on eac	h line. nとひか									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a										
	Examiner		- 1		hvoni	C Q	enal	F	ailu	10				
		ь	Sequentially list conditions, if any, leading to immediate	b	as a conseque			•	0.110					
	nsit	Examin	Cause (Disease or injury											
	ad-tra	xa	that initiated events resulting in death) Last	c Due to (or	as a conseque	ence of):							-	
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89		0.3		d										
Box	Physician: The law requires thet the death certific this certificate has been signed by the ettending prial director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Da	ate of delive	ery
	death e ette d for	lcla	in the past 12 months?	4□Pregnan	n 2 ☐ Fetal of t at time of dea]Ectopic pred]Other (spec					М	onth	Day Year
P.0	thet the de led by the e detached i	hys	9 □ Unknown	9□ Unknow	n									
	res the igned l	by P	Part II. Other significant conditions of				nderlying cau	ıse give	n in Part I.		23e. Did to	bacco use con	tribute to th	ne cause of death?
P. S.	quire n sig uld b		Diabetes	· Mel	litus						1 🗆 Y	′es 2□No	3 🗆 Prob	ably 4 Minknown
00	s been should	lete	clostrac	lium .	4:41 in	11.	col;	tis			24a. Was	an 24b.	Were auto	psy findings available
of Vital Records,	The lay	Completed	Hupert			-1(-					autop	rmed2	prior to cor death?	mpletion of cause of
ta	ician: Th certificate rector, pag		25. Was case referred to medical	(4) 7,0					36 Place	of Dooth	1 Yes	2/2 No	1 🗆 Yes	2 L No
>	yeician: is certific director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗐 Inp	atient 2□F	R/Outpatier	it 3 DOA	Othe			ne 5 ☐ Resid		her (Specifi	<i>u</i>)
	9 Phy eral (27. Manner of Death	28a. Date of (Month,		28b. Time o		c. Injury Work			28d. Describe h			//
ion	Attending P ir death. ector: After t by the funera	atlo	1 ■Natural 5 □ Pending 2 □ Accident investigation		Day rear)	Injury	м		? ′es 2 🗆 N	lo				
Division	Atte	IIC.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	280. Place of	Injury - At hon	ne, farm, str	eet, factory,	office		1	28f. Location (S	Street and Num	ber or Rura	l Route Number,
ā	s afte	Certification:	4 Ditomode	Building	, etc. (Specify)						City or Tow	n, State)		
						and due to the	ause(s) and m	anner as st	ated.					
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date sign							Jate and place,	and due to	rne cause(s)					
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	hude					number	a /.		29d. Date signe		Day, Year)
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			30. Name and address of person who			23a) (Type,	Print)	112	6 0	pal	(our	+	1.5	
121	4-3		FARID MU	RSHE	ν ————————————————————————————————————				Hag	erst	, who	WD.	2174	10

Registrar

			T -	Maryland / Depa		ealth and Me	ental Hygie	_	6 17155
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physi	ician dical	Margaret Madeleine STANN	ARD			Month MAY	$13^{\text{Day}}, 2006$	11:45 P ^M
	Exam		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or	Location of Death		4c. County of [Death
			Reeder's Memorial Home		Boonsbo			Washin	
	Funera		1 T 14 0 M F	Age (In yrs. last birthday) 89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9.	Birthplace (State or Foreign Country)
	Directo	or	Usual Residence of Decedent	0.9		(Oct. 19,	1916 N	linnesota
4	faryland show		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
<	a-fst	ctor	Maryland Washington	Вос	onsboro				11 Yes 2 No
	ith the	Dire	10e. Street and Number		10f. Zip Code		10g	. Citizen of Wha	t Country?
9	ath w	ia i	141 S. Main Street		2171			USA	
Ę	ter dea items	by Funeral Director	11. Marital Status 12. Was Decede Armed Force 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2	int Ever in U.S. 13.1	Was Decedent of His If Yes, specify Cubar	panic Origin? (Spec i, Mexican, Puerto R	cify Yes or No- lican, etc.)		American Indian, White, etc.
ğ	036 Outs after death with the Maryla rel', or Items 23a or 28a-1 shot	by	3 Widowed 4 Divorced Year or Date		1☐ Yes 2☒ No	Specify:		Specify:	white
a	5-0 72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	tion	16	b. Kind of Busin	ess/Industry
2	1215-0036 within 72 hours after death with the Maryland one. Than "neturel", or Items 23a or 28a-f show he Medical Examinat the notifiest at	Completed	Elementary/Secondary (0-12) College (1-4-12) 5	Of 5+1	kind of work done do DO NDT use retired)	ning most of working			
4	CO B G F	S	12 5	te	eacher	18. Mother's Name		schools	
A.	E galage	Be.	Gerard Lawrence Stannard				aret McM		
В		은	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a				te. Zip Code)
Ē	Z da Z		Tim Davis - Personal Rep		Maryland			•	
0	or Health filem 27 I		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place			c. Location - City	
-]	Pages ment of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from States 1 ☐ Donation 5 ☐ Other (Specify)		M. Ch.Cer		06 Wc	1fsvill	e, Maryland
ume:	Baltimore permit Pages 1: Department of He Important: If iten any in ury or oth	once.	21. Signature of Funeral Service Licensee		2. Name and Address	TII	NNICH FU		
D	m 902 e	OI	dout Ill fun		415 E. Wil				- I was a second of the second
4	1000		23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do not ent n line.	ter the mode of dying	, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
•	Physicial /Medica		Immediate Cause (Final disease or condition resulting in death)		mohiti f	Pulmon	Dine		7
	Examine			as a consequence of):					
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):					
	760, be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
	760, te be exergician are ysician are		resulting in death) Last Due to (or	as a consequence of):					
	- W - 0	dicai	d						
	Box 68 leath certifical attending phy for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome	me of preopancy					
	Bo eath c atten	cian	in the past 12 months?	n 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
	P.O. I	nysi	1 Yes 2 No 9 Unknown 9 Unknown						
	IS, P res that igned b	by P	Part II. Other significant conditions contributing to deat	h but not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	co use contribut	e to the cause of death?
	of Vital Records, Physicien: The law requires to this certificate has been signe rat director, page 2 should be or	ed k	Hypertylin De	- extra			1 ☐ Yes	2 □ No 3 □	Probably 4 Linknown
	Recorded law required bear should	Completed					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
	The trace has page	Com					performed	d? deat	h? Yes 2□ No
	of Vital F Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospital:			26. Place of Death (
	Of Physical this cral dir	-T	T Tes 2 GAO		t 3 DOA Other	4 Nursing Home	e 5 Residence		Specify)
	on oding Fall After funer	tion	27. Manner of Death 1 Natural 5 Pending (Month, 1) 2 Accident investigation	Day Year) Injury	Work?	es 2 No	d. Describe flow i	nqury occurred	
	Division For Attending after death. Director: After din by the fune	Ifica	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, stre			f. Location (Stree	t and Number o	r Rural Route Number,
	Div elor safte el Dire	Certification:	4 ☐ Homicide determined building,	etc. (Specify)			City or Town, S	tate)	
	Division o To the Hospitel or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edical (29a. Certifier (Check only one) 1	s of examination and/or inv	h occurred at the time vestigation, in my opi	, date and place, an nion, death occurred	d due to the caus f at the time, date	e(s) and manner and place, and	r as stated. due to the cause(s)
_	To the within To the	Me	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (M	onth, Day, Year)
			- Com the		0 12	1019	M	AYILL	2006
	611 14		30. Name and address of person who completed cause of						
	SH-15			40 MILL STRE	EET, HAGER	STOWN, MD	21740/	301-739	-7100
	Regis	State strar	MAY 1 7 2006	istrar's Signature	rested				

State of Maryland / Department of Health and Mental Hygiene

					aryland	•	cate of	Death	F	leg. No.	UD	1/100
	Disconini		1. Decedent's Name (First, Middle, La	•				*-	2. Date of Dea	th Day	Year	3. Time of Death
	Physici /Medio		William Cheste	er Shaffer					May	10	2006	10:20 PM
	Examir		4a Facility Name (If not institution, given						Location of Death	4c. County		_
			Julia Manor Heal			the same of the sa	Under 1 Yea		stown			County
Ī	Funeral Director		5. Social Security Number 219-44-3785 Usuel Residence of Decedent	Sex 7. Ag	e (In yrs. lasi 59		nths Days				Mary	ace (State or Foreign ry) land
	w #		10a. State 10b. County		10c. City, T	own or Locatio	n				10	d. Inside City Limits
	Mery	į	Maryland Washin	ngton		Hage	rstow	n				1 Yes 2 □ No
	th the	Director	10e. Street and Number			10	of. Zip Code		1	l0g. Citizen of	What Count	ry?
	ath w	rai	333 Mill Street					21740		U.S		
15-0020	be filed within 72 hours efter death with the Merylend ital Hygiene. d other than "natural", or iteme 23a or 28e-f show evant, I'm Medical Examiner must be incitited at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 2 Yes 2 ☐ h If Yes, Give Year or Dates:	₆ 10–1	9-66 ff Yes 8-72 1 1		Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)		ce - America ck, White, e y: White	tc.
2	72 hg	eted	15. Decedent's E (Specify only highest gre	ducation ede completed)	1	6a. Decedent's	Usual Occu	ipation during most of wo ed)	rking	16b. Kind of B	usiness/Indi	ustry
12	Man vithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		OT use retir 1 Offic			Bank		
	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last	1			OTTE		me (First, Middle,			
Maryland	d be entai ced o	To Be							Ecile B			
ar Z	2 should by end Menta is marked sumatic er		Chester Berlin S 19a. Informant's Name/Relationship			19b. Mailing Ad	Idress (Stree	ot and Number or R				Code)
	D = N =		Amy L. Brooks (d	daughter)		50 Fenw	zick D	rive Mart	insburg V	w. VA 2	5401	
ore	ges 1 en it of Healt if itam 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Plac	e of Disposition etery, cremator	(Name of	ace)	Date	20c. Location	City or Tow	,
Ĕ	Parit: Parit		4 Oonation 5 Other (Special		Ced	ar Lawn	Memo:	ria Pk	5–15–06	Hager	stown	Maryland
Baltimore,	permit. Page Depertment of important: if any Injury or once.		21. Signature of Funeral Service Lice	A Zin	. ,				ouglas A N. Hage	_		ral Home and 21742
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lir	the death. I	Do not enter the	mode of dy	ing, such as cardia	c or respiratory arr	est,		Approximate Interval Between
The state of the s	Physician			Λ.Ξ	0						1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Alhero	SULYE	tre c	ard	vovascul	or de	leux	1 1	104
	ji.	Je.		^	Due to (or as	e consequend	e of):	to lascul			1	1710
	cuted nd ransit	E	Sequentiatly list conditions.	b. Congr	Due to (or as	a consequence	* A(1	rucho				11 /2
Š	ficete be executed physician end st the buriel-transit	edicai Examiner	Sequentiatly list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Dial	e La	1110	Dite				i	ITX
08/PU	ohysic the b	dica	that initiated events resulting in death) Last	C.	Due to (or as	a consequence	e of):	, , , , , , , , , , , , , , , , , , ,				
ς ×	ding ph	$\mathbf{\Sigma}$		d								
õ n	atten for u	clan										
j.	es thet the death ce igned by the attendi be deteched for use	Physician/	Part II. Other significant conditions of	ontributing to death bu	at not resultin	ig in the underly	ying cause g	iven in Part I.		obacco use co ea 2⊡ No	ntribute to t 3 ☐ Proba	the cause of death?
S,	s thet med t	by P								5a 2 110	0	, y
ecord	requir	Completed						·	24a. Was a perform		avai	e autopsy findings lable prior to pletion of cause eath?
r	sician: The law certificete hes t lirector, page 2 s	E							101	E 2540	10	Yes 2□ No
VITal	ysician: is certifica director,	Be	25. Was case referred to medical examiner?		· · · · · · · · · · · · · · · · · · ·				ath (Check only on	(6)		
5	el chis	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:		Outpatient 3	LI DOA		forme 5 Reside			
5	ding f h. After funer	tjon	1 □ Pending	28a. Date of Injur (Month, De)	Year)	Injury N	28c. Inju Wo	ork?]Yes 2∐No	26d. Describe no	ow injury occur	iea	
UIVISION	ii or Attanding Phys s efter death. I Director: After this id in by the funerel di	Certification:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e Ope Olege of Inju	ury - At home c. (Specify)	, farm, street, f			28f. Location (Si City or Town		er or Rural	Route Number,
ב	oftal o		00-0-16									
	To the Hospital of within 24 hours en To the Funeral Discompletely filled it	edicai		niner: On the basis of and manner sta	examination							
	o the outling of the outling out	Me	29b. Signature and title of certifier	and marrier sta			29c. Licen	se number	2	9d. Date signe	d (Month, D	ay, Yeer)
	F > F 0			6				P5232	7	5/111	6	
	, , , ,	ŀ	30. Name and address of person who	completed cause of de	eath (Item 23	a) (Type, Print)						
DH	1-44/		Dr. Sarid Mursh		pal Co	urt Hac	erstov	vn Maryla	nd 21742			
	Sta Registr	_	31. Date filed (Month, Dey, Year)	32. Registra	ār's Signature	1	20	2				

		4	For State Registrar	State	of Marylai			nt of He te of E		and M	ental I	Hygie Reg	- Z U	06	1715	7
	19.4		Decedent's Name (First, Middle,	Last)							2. Date of Month	f Death	Day	Year	3. Time of Death	
	Physicia		Marv	Lorett	a Sh	ea					May	1		006	1:32 P.	A
	/Medic Examin		4a. Facility Name (If not institution,				4b. City	Town, or	Location o	of Death			4c. County	of Death		
	LXamiii	-	Shady Grove Adv	entist H	ospital		Ro	ckvil	lle				Mont	gomei	v	
_	Funeral			S. Sex		. last birthday)	If Unde	r 1 Year	If Under	24 Hrs. Min.	8. Date of (Month	f Birth	937	9. Birthp	tace (State or Foreig	n
	Director		109-20-1470	1□M 2⊠F	8	30 Yrs.	Months	Days	Hours	Min.	Feb.	19,	1926		York	
	0		Usual Residence of Decedent													_
	how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	Od. Inside City Limit:	
:	e wa	cto	Maryland Montgo	mery	(Gaither	sbur	3							1 X Yes 2 ☐ N	_
	or 28	Funeral Director	10e. Street and Number				10f. Z	p Code				10g	. Citizen of W	Vhat Cour	itry?	
	23a	<u>e</u>	226 West Deer P	ark Road				20877					USA			
,	90	Ine	11. Marital Status	12. Was De Armed F	cedent Ever in torces?	U.S. 13. \	Was Dece f Yes, spi	dent of His	spanic Orig	gin? (Spe 1, Puerto	cify Yes o Rican, etc.	r No-		e - Americ k, White,	an Indian, etc.	
2	or it	五	1 ☐ Never Married 2 ☑ Marrie	d 1 ☐ Yes If Yes, G	2X No		1 ☐ Yes	2 🔀 No	Specify:				Specify			
Š	iral',	d by	3 Widowed 4 Divorced	Year or	Dates:									Whi		
5	nerti	Completed	15. Decedent's (Specify only highest		1)	16a. Deced	kind of w	ial Occupa ork done di ise retired)	uring most	t of worki	ng	16	b. Kind of Bu	isiness/in	dustry	
7	hen he	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)								II	_		
V .	lied y		12 17. Father's Name (First, Middle, L	act)		I	Iomen	-	18 Mothe	ar's Name	(First Min	ddle Ma	Home iden Sumam	-		-
	ouid be liled within 72 hours after death with the Maryland Mental Hygiene. A street of the rhan "natural", or Iteme 23a or 28a-f show after other than "natural", or Iteme 23a or 28a-f show after event, the Madical Examinar must be notified at	Be							TO. MIOTING	or o rearrie				_	_	
Š	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Interportant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show eny Injury or other traumatic event, the Madical Examinar must be notified at other.	ဥ	Robert 19a. Informant's Name/Relationshi	McDad	e	10h Mailie	a - Adden	a /Straata	ad Numba	or or Pur	Mary		McAll:			
_	and and and and and and and and and and	1				1	•						-			
	1 and Health am 27 ther tr	-	John J. Shea/Hu 20a. Method of Disposition	spana	20h.	Place of Dispo			Park		l, Gä. Date		c. Location		. 20877	_
	Pages nent of h		1 ₺ Burial 2 □ Cremation	3 □Removal from	n State	cemetery, crer	natory or	other place						•	111 273-2	
	tant:		4 □ Donation 5 □ Other (Sp.		A	1 Souls					/2006				Maryland	
20	permit. Depertr Import		21. Signature of Funeral Service L	icepsee	. U V.	200							1 Home			
_	20 = 9 a		Michi	N W	سر									g, M	D. 20877	_
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that inly one cause on	caused the dea each line.	ath. Do not ent	er the mo	de of dying	g, such as	cardiac c	or respirato	ry arrest			Approximate Interval Between Onset and Death	
į F	Physician		tmmediate Cause (Final disease or condition	· AR	RHYT	MMI	4							ď	VINU /EI	
· E	/Medical		resulting in death)	Due to	o (or as a conse		,								(П
Н	Examiner		Sequentially list conditions.	J. 28	3 TIC	SNO	CK								HOUR	
-	= g	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse		~ ^ .				, h					
	ocute nd trans	E	that initiated events	c. V.	イントア		アナィ	2 (NH	∋ 07	w			_		
Š	e exe ien a uriat-	ŭ	resulting in death) Last	Due to	o (or as a conse	equence of):										
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õ	ng pl	Ved	IF FEMALE:										1			_
X Q Q	th ce tendi	hysician/Me	23b. Was decedent pregnant in the past 12 months?		utcome of pregr birth 2 Fet		Ectopic	oregnancy					23d. Dat Mor	e of delive	ary Day Year	
	ed fo	SC	1 ☐ Yes 2 🗹 No	4□Pre 9□Unk	gnant at time of	death 5	Other (s	pecify)					14101		Duy Tour	
r S	at the	Phy	9 Unknown								-					
_ ທໍ	w requires that the death certific been signed by the attending p should be detached for use as	þ	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying	cause give	n in Part I.	•					ne cause of death?	
coras,	aquir en si ould											1 L Yes	2 No	3 ∐ Prot	ably 4 Unknow	n —
ပ္မ	law re as be 2 sh	ple										Was an autopsy	24b. V	Vere auto	psy findings availabl mpletion of cause of	le
r	e - e	Completed									10 Y	performe	d2 0	death?	_	
	icien: Th certilicate rector, pag	0	25. Was case referred to medical						26. Place	of Death	(Check o					
>	2 10 =	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	☐ ER/Outpatier	nt 3 🗆 🛭	OA Othe	ar: 4 □ Nu	ursing Ho	me 5 🗆 I	Residenc	ce 6 □Othe	er (Specit	y)	
	g Phys ter this heral di	ë	27. Manner of Death	/1 40	e of Injury onth, Day Year)	28b. Time o Injury	f	28c. Injury Work	at		28d. Desci	ribe how	injury occurr	ed		
DIVISION	Attending ir death. ector: After by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investig		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	М		Yes 2□	No						
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5	s ette	Certification;	4 Homicide building, etc. (Specify) City or Town, State)													
	To the Hospital or Attendi within 24 hours eller death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying	Physician: To t xaminer: On the	ha best of my kn	nowledge deat	- Securre	d at the tim	a Jata an	id place	and due to	the caus	se(s) and ma	inner as w	talied the cauca(a)	
	he H in 24 he Fi plete	ledical	one)	and ma	nner stated.	ation and/or in	· · · · · · · · · · · · · · · · · · ·	π, m my op	Julion, Ues	an occur	on ar mar n	-,-				
	with To t	Σ	29b. Signature and title of certifier	٨٠٨				9c. License		0.5			Date signed			
ľ	7		Dunjoh	1 MD			1	300	57°	12.	-7	0	CHY (3,	2006	
	1		30. Name and address of person v		use of death (Ite	em 23a) (Type,	Print)							212	Δ.,	
			SAFYJOI	HNM	0 SV	am 23a) (Type,	021	グラ	AD	UE	7117	1	H 031	- (()	7	
	Sta Registr		31. Date filed (Month, Day, Year)	2006	Registrar's Sign	nature	sell!									

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 17158

		1- For State Registrar	-	Certific	ate of E	eath		R	eg. No.	
Physicia	n/	Decedent's Name (First, Middle, Last	st)					2. Date of Dea Month		3. Time of Death
ledical Examir		James Reed Tur	ner, Jr.					May 11, 2	006	0510 hrs
)		4a. Facility Name (if not institution, given Route 210 in front of 5460)				City, Town, or I ndian Head		Death	4c. County of Dea Charles	th
Funeral		Social Security Number 6. S	ex 7. Age (In yrs. last bir	rthday)	If Under 1 Year	If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9 B	
Director			M 2 F 24	:	Yrs.	Months Days	Hours	Marc Marc	h 22,19 ^{Fore}	^{ountry} Maryland
any	H	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Towr	or Location					10d. Inside City Limits
<u> </u>		Maryland Charles	2	Tnđi	an Hea	ad				1 XYes 2 No
Aaryland 28a-f show 1 at once.	흸	10e. Street and Number				Of, Zip Code		1	0g Citizen of What Co	untry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Director	27 Cypress Place				20640	0		U.S.A.	
th with	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?	er in U.S.				n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black,
or it	劃		1 Yes 2 X	No	1 ×	es 2 No	specify:		Specify: W	nite
rs aft ural" mine	ᅙ	15. Decedent's Education (Specify of	or Dates:	eted) 16a.		X		nd of work done	16b. Kind of Business	
2 hou "nat	ig-	Elementary/Secondary (0-12)	College (1-4 or 5+)			of working life.				,
136 thin 7 than	ompleted	12		Sh	eetmet	al Fab	ricato	or	Heating 8	A/C Co.
5-0(ed wi tygier other	ड़ी	17. Father's Name (First, Middle, Last)					Name (First, Middle, I	Maiden Surname)	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	a	James Reed Turne					Tammy	y Lynn Ros	s	
21 hould hould Me is ma	ဥ	19a. Informant's Name/Relationship (*		1/0	_				nber, City or Town, Stat	
MD nd 2 shc alth and nn 27 is aumati		Krystal M. Turne:	r Wife	an Di	7.D.	45.1	44.4	Indian Hea Date	d, Md. 2064	
ore, s l au of He of He If ite		1 X Burial 2 Cremation 3	Removal from State	crema	itory or other	n (Name of cen	16	2006	200. Location - City C	TOWN, State
imC Page ment tant:		4 Donation 5 Other Specify	r:	st. c	riar res	Cellect	ET À			ad, MAryland
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than injury or other traumatic event, the Medical		21. Signature of Funeral Servi	msee M00	668	Wil.	e and Address	of Facility unera	l Home, P.	A. n Head, Md.	20640
Physician	\dashv	23a. Part I Enter Le disease, or com	plications that caused th	e death. Do r	not enter the	Mode of dying,	such as car	diac or respiratory arr	est, shock, or heart	Approximate Interval
/Medical	C II	failure. List only one cause on e	ach line. Multiple Injuries							Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	uence of):						
S		Sequentially list conditions, b								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uence of):						
	Exam	events resulting in death) Last	Due to (or as a consequ	uence of):	_					
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be exe	edical	UNPENDED	AMENDED							
760, ficate be g physici	ΣI	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome			1 2 <u>- 1</u>	Estania	aroanana.	23d. Date of delive	·
	cian	past 12 months?	Pregnant at tir			death 3 (Ectopic p	bregnancy	Month	Day Year
Box 687 ne death certific the attending indefor use as the	Physiciar	1 Yes 2 No 9 Unknow	n g Unknown		Ollier	(Opcolity)			1	ì
ision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certi releath. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions	contributing to death b	out not resulti	ng in the und	erlying cause g	iven in Part		obacco use contribute to	
s, P.O. irres that the signed by 1	d by							1 Yes	s 2 V No 3 Pro	bably 4 Unknown
of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should	Completed							24a. Was autop		utopsy findings available completion of cause of
Reco	티	autoperformed? 1 ✓ Yes 2 No 1 ✓ Yes								
tal Rectian: The certificate ector, page		25. Was case referred to medical				26 Place	of Death (C	Check only one)		
Vital ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/0	Outpatient 3	DOA -	Other ₄	Nursing Home 5	Residence 6 🗸 Othe	er: Scene
of Vit Jing Physic After this funeral dire	닐	27. Manner of Death	28a. Date of Injury (Month, Day Yea May 11, 2006	28b	. Time of Inju	ry 28c. Injur	y at Work?		how injury occurred struck by motor v	ehicle
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Division tal or Attendi rs after death.	ific	3 Suicide 6 Could no	t be 28e. Place of Injui	y - At home,	farm, street,	factory, office b	uilding, etc.	or Town, S	state)	ural Route Number, City
D pital ours a filled	Certification:	4 Homicide determine	(Specify) Majo	r Road / F	lighway			Route 210 i	n front of 5460, In	dian Head, MD
Divisor the Hospital or A thin 24 hours after the Funeral Dirempletely filled in brightely filled in brigh	cal	one) Madical Event	cian: To the best of my	-						
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	2	250. Signature and title of certifier	Mann.			O.C.I				omm, Day, rear)
		my	MULLE	11		0.0.1	VI.∟.		May 11, 2006	
2000		30. Name and address of person who Carol Allan, MD Assist	completed cause of dea ant Medical Exami		Penn Str	eet, Baltime	ore MD	21201		
M5								-1201		
St	ate		32. Fegistrar's	Jigi latule	Som	20				

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IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Month									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I. 1 Yes 2 No 3 Probably 24a. Was an autopsy in prior to completion	Year								
24a. Was an autopsy in autopsy prior to completic									
performed death? 1 Yes 2 No 1 Yes 2 Yes 2 No 1 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2	autopsy prior to completion of cause of death?								
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27. Manney Death 1	Number,								
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Attention, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 29d. Date signed (Month, Day, Y	use(s)								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 MCD/CA/ C6N/61 ROAD 62ASONVIII6, WC/ State 31. Date filed (Month, Day, Year) 2006 Registrar's Signature									

Dh	ion	1- State of Maryland / Der 26 per verb., G856		2. Date of De.	ath	Year	3. Time of Death
Physic /Med		Edward Francis Thompson		May	17	2°006	5:39p
Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County Ker		
5		325 Race Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Millington (i) If Under 1 Year If Under 24 Hrs.	8. Date of Birt			ce (State or Foreig
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 2 of 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 2 of 8. Sex 8. Age (In yrs. last birthday 1. Age (In yrs.	Months Days Hours Min.	8. Date of Birt (Month, Da 07/27	y, Year) 7/1932	Country	y)
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28a-f	ect	DE New Castle Wilmin	19ton 10f. Zip Code		10g. Citizen of	Mhat Causta	
aa or	Ö	2407 Carter Street	19802		USA	What Country	y:
death me 2	Completed by Funeral Director		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No	- 14. Rac	e - Americar	
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ural',	d b	3 Widowed 4 Divorced Year or Dates:			Specify	Bl.	ack
"nat	iete	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e <i>kind of work d</i> one during most of work DO NOT use retired)	ing	16b. Kind of B	usiness/Indu	stry
within ene. then "	E C	Elementary/Secondary (0-12) College (1-4or 5+)	ent Finisher		Cons	struc	tion
Hygi other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,			CIOII
Mental Mental rked c	To B	Unknown	Ethel	Thomps	son		
and Menie marke	-	19a. Informant's Name/Relationship (Type, Print) 19b. Maii	ling Address (Street and Number or Rur	al Route Numbe	r, City or Town,	State, Zip C	ode)
and and m 27 in 27 is			Box 62 Millingt	on, MI	21651	i	
Pages 1 nent of H int: if iter		20a. Method of Disposition 20b. Place of Disposition Burial 2 Cremation 3 Removal from State	osition (Name of ematory or other place)	Date	20c. Location -	City or Town	n, State
tant		4 □Donation 5 □Other (Specify) John We	esley Cem. 5/23	3/2006	Millir	gton	, MD
perinn. Taggs I am 2 Shouto belied when it 2 hours after death with the waysa. I my perinn. Taggs I am 1 he waysa. I my perinn. I fem 27 ie marked other than "natural" or iteme 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 'ellows, Helfent 170 W. Cypress S	ein &	Newnam	Fune	eral Ho
Ite be executed XXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):					
2 2		IF FEMALE: 23b. Was decedent pregnant 1	□Ectopic pregnancy		23d. Dat	e of delivery	
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med		Other (specify)		Moi	nth Da	ay Year
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hysician: The law his certificate has I I director, page 2 s	Completed			24a. Was a autop: perfor	med?	rior to comp leath?	findings availabletion of cause of
Physician: this certifica ral director, p	BeC	25. Was case referred to medical examiner?	26. Place of Death		·		
Thysic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me # Resid	ence 6 Othe	er (Specify)	Sister's Home
After t	<u>0</u>	27. Mann of Death 28a. Date of Injury 28b. Time (1 Natural 5 ☐ Pending (Month, Day Year) Injury	Work?	28d. Describe h	ow injury occurr	ed	
after death. Director: After	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building etc. (Specify)	M 1 Tyes 2 No	28f. Location (S	treet and Numbe	ar or Rural R	oute Number,
lotte nospita or Attending Fri within 24 hours after death To the Funeral Director: After th completely filled in by the funeral				City or Tow			
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nestigation, in my opinion, death occurr	and due to the c ed at the time, d	ause(s) and mai late and place, a	nner as state and due to th	ed. e cause(s)
드 는 돈 말	×	29b. Signature and title of certifier	29c. License number	1 2	29d. Date signed	(Month, Day	y, Year)
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to m	ate rar	Regional Hematologya Ducalogy	PA HOLOUF. G. PAM.	4701 (CerCer Gletari VAVE	ter.	antan K

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JOAQUIN TEREGEYO 3:55 а. м 2006 May 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Director 586-10-6807 65 Yrs. July 24, 1940 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County show 10d. Inside City Limits ral', or Items 23s or 28s-f shore Examiner must be notified at Directo MP (none) 1 ☐ Yes 2 ☐ No Saipan 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? San Vicente Village 96950 United States Funeral Peges 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No þ Specify: Specify: Pacific Islander 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other then "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Finance & Accounting 12 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Odorico McG. Seman ٩ Enriqueta Peter Teregeyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tre San Vicente Village, Saipan, MP. (Marianas Pacific) 96950 Ana Teregeyo (wife) 20b. Place of Disposition (Name of cometery, crematory or other place)
Our Lady of Mount Carmel 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Pege Depertment o Importent: ff eny injury or once. May 19, 2006 Saipan, MP. Cemetery Pay 19, 2000 Salpan Pir.

22. Name and Address of Facility Advent Funeral & Cremation Services 21. Signature of Funeral Service Licensee M00982 7211 Lee Highway Falls Church, Virginia 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Stomach Cancer vears /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Stomach Cancer unknown Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed C. Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year signed by the at d be deteched for 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ should I Completed 1 Yes 200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed? Division of Vital 1 Yes 2 No 1 Yes ZXXVo Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? XX atural 5 Pending efter death.
I Director: Aff 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide within 24 hours efter de To the Funeral Directo completely filled in by the 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dealh occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D21531 May 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Pushkas, 11510 Old Georgetown Pike Rockville, MD 20852 M.D. 32. Fegistrar's Signature State Registrar

/sicia		1. Decedent's Name (First, Middle, La	ist)	U	ertificate of Death	2. Date of Dea	Reg. No.	3. Time of Death
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The Call	ctor	10a. State 10b. County Maryland Calvert		Oc. City, Town or Broomes				10d. Inside City Limit
I be no	Funeral Director	10e. Street and Number 8710 BroomesIslan	nd Road		10f. Zip Code 20615		10g. Citizen of What C	
ST DIE	inera	11. Marital Status	12. Was Decedent Eve		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-		erican Indian,
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any one		Date 1	MI		905 Galesville Ro			
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is .	Examiner	cause. Enter Underlying	/					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 2037 PM nompson 2006 Was /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHOTOWY

If Under 24 Hrs. 8. Date of Birth
Hours Min. OCTOBER 5, Examiner Ken Security Number 6. Sex (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 CT **Funeral** 1 ☐ M 2 🂢 F 1910 135-38-0646 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 EAST CAMPUS AVE. 21620 238 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Iteme 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEOWNER OWN HOME n and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth eny Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS THOMAS REEVES BETTY PETERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REEVES THOMPSON/SON C/O ALEX RASIN 200 COURT ST, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 05/18/2006 STEVENSVILLE, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS. HELFENBEIN AND NEWNAM
130 SPEER ROAD, CHESTERTOWN, MI 21. Signature of Funeral Service Licensee AM FUNERAL HOME MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between fmmediate Cause (Final disease or condition resulting in death) Onset and Death BILMIEKAZ **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MAARI 3 ☐ Probebly 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 atural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Coufd not be determined 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) of death (ftem 23a) (Type, Print) 45 31. Date fifed (Month, Day, Year) 32. Registar's Signature State MAY 1 8 2006 Registrar

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	Physici	an	1. Decedent's Name (First, Middle, Las	•							Date of Dea Month	Dav	Year	3. Time of Death	
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J.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depermient of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow with fujury or other traumatic avent, the Medical Examinat must be notified at ances.		20a. Method of Disposition	D 1/ 0: .	20b. P	lace of Dispo	-					20c. Location			
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Baltimore,	permit. Depertrimports Imports any injugany		21. Signature of Funeral Service Licen		MINNICH										
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	ha Hospi n 24 hou ha Funst	Medical	29a Cartifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis of and manner s	of examinal	w/adga death tion and/or inv	oncurred sestigation,	it the tim in my op	a date and inion, deat	plane, a h occurre	nd due to the et d at the time, da	tuss(s) and rate and place	and due	stated. to the cause(s)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)															
			Muchael	11. Me	land	no		04	166)		5 -	15	00	
100	4-1		30. Name and address of person who of Michael D-	necon	cek	1111	o /	redr	ed c	lin	nus 1	regero	tev.	mo	
i	Sta Registi	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature													

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Melvin L. Tobery, Sr. May 15, 2006 10:05 P/M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick 106 Monroe Avenue Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**귳**M 2□F Yrs. 63 Director 218-40-2818 January 27, 1943 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21701 U.S.A. 106 Monroe Avenue Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2K No Specify Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tent: if item 27 is marked ott jury or other treumatic even Be Charles R. W. Tobery Claudia Lee Sier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Charlotte Tobery - wife 106 Monroe Avenue, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: if any injury or any injury or ance. 5-19-2006 Frederick, Maryland Resthaven Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal ve of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Panulle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10005 /Medical **Examiner** Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No 24a. Was an Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No autopsy certificate 1 Yes 2 12 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation death. 1 TYes within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatu title of certifier 29d. Date signed (Month, Dey, Year) Auson Drive Name and ad who completed cause of death (Item 23a) (Type, Print) ZIHOYE B 32. Register's Signature State 2006 ▶ Registrar

		For State Registrar	State of	Marylar		artment of tificate of		Mental Hy	giene Reg. No	ZHHb	17166
Physicia		1. Decedent's Name (First, Middle, Las	t)	-				2. Date of D Month	Da	y Year	3. Time of Death
/Medica		Nancy Krug Town							1	2006	8:00 ^A
Examine	er	4a. Facility Name (If not institution, give	street and num	ber)			or Location of De	eath		. County of Deal	
		Casey House 5. Social Security Number 6. Security	ex 7	7. Age (In yrs.	last hirthday)	Rockvi.		Irs. 8. Date of B		ontgomer	· y thplace <i>(State or Foreigr</i>
Funeral Director			M 20XF	. rigo (iii yio.	66 Yrs.	Months Days			av. Year	Co	ountry)
	}	Usual Residence of Decedent		7							
who w	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
188-f	Director	Maryland Howard		Col	Lumbia	T. 0. 1.			10- 6	See - CMb - C	
a or 2	5	10e. Street and Number	#1/-	7		10f. Zip Code 21044			USA	tizen of What Co	ountry?
na 23	Funeral	10641 Gramercy Pl	12. Was Dece		J.S. 13. V	1	Hispanic Origin?	(Specify Yes or N		14. Race - Ame	erican Indian,
r Item	Fun	1 ☐ Never Married 2 X Married	Armed For	ces? 2 📉 No	1	f Yes, specify Cu	ban, Mexican, Pu	erto Rican, etc.)		Black, Whit	
o, le		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1□Yes 2XINo	Specify:			Specify: Whi	ite
dical	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	tent's Usual Occi	e during most of v	vorking	16b. K	ind of Business	
Pan a	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)	1	DO NOT use retir	ed)		0		
nt, in		17. Father's Name (First, Middle, Last)	4		Homen	aker	18 Mother's N	lame (First, Middl		1 Home	
c eve	o Be	Walter Krug						o Shiple			
D D D D D D D D D D D D D D D D D D D	ပ္	19a. Informant's Name/Relationship (ype, Print)		19b. Mailir	ng Address (Stree		Rural Route Num		or Town, State, 2	Zip Code)
alth ar 27 lo 27 lo rr trau		Anthony M.G. Town	send/hu	shand	10641	Gramer	v Place	#147 Co	lumbi	ia. MD 2	21044
item item othe		20a. Method of Disposition		20b. i	Place of Dispo	sition (Name of natory or other pi		Date		ocation - City or	
int: If		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		iaia I		,	tory 05	/17/06	Be1t	sville,	MD
Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, its Medical Examinat must be notified at once.		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or comshock, or heart failure. List only	olications that ca	MO12	251 Be	verly L	. Heckro		. Cla		Approximate Interval Between
Medical kaminer		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (o	omyopat orasaconsec stive I	quence of): Heart F	ailure					Onset and Death
hysicié the bu	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Chron	ic Obst	tructiv	re Pulmo	nary Dis	ease			
by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		nth 2 ∐ Feta ant at time of c	aldeath 3□	Ectopic pregnan Other (specify)	су			23d. Date of del Month	livery Day Year
engi De q	þ	Part II. Other significant conditions of	ontributing to de	ath but not res	sulting in the u	nderlying cause g	ıven in Part I.		tobacco		o the cause of death?
9.2	Completed								opsy ormad?	prior to death?	utopsy findings available completion of cause of 2 No
his certificete h I director, page	Be	25. Was case referred to medical examiner?	Hospital:			_ 0		Death Check only		v	
After t funera	ation: To	1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending 2 Accident investigation	28a. Date o		28b. Time of Injury	28c. Inj		g Home 5 Res			cly) hospice
within 24 hours efter death. To the Funeral Director: A completely filled in by the funeral properties.	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place	of Injury - At h ig, etc. (Speci	iome, farm, str fy)	eet, factory, office	•		(Street ar own, State		ural Route Number,
within 24 hours e To the Funeral I completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the niner: On the ba and mann	sis of examina	owledge, deatl ation and/or in	n occurred at the vestigation, in my	time, date and pla opinion, death of	ace, and due to the courred at the time	cause(s , date an) and manner as d place, and due	s stated. to the cause(s)
To t	Σ	29b. Signature and title of certilier	/		No. 10		nse number			te signed (Mont	
		1 1 1 1 1	v /		.70	D356	35		May	15, 200)6
		30. Name and address of person who		·		•		,			
		Joseph Kaplan, M.	D. 6001	Munca	ster Mi	11 Rd.	Rockvill	e, MD 20	855		
Stat Registra		31. Date filed (Month, Day, Year)	006	gistrar's Sign	ature & A	rach .					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Barbara Α. Upperman May 13, 2006 12:30 a M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. Cilv. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 □XF Yrs Director 214-28-7599 74 1932 Washington, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 238 20901 10804 Breewood Road USA death Funeral or Iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Tyes 2 No Specify: Specify: à Year or Dates: WWII 3 X Widowed 4 ☐ Divorced "neturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrator Telecommunications 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other entity groups other treumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Harry L. Stoneburner Katharine Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine M. Redner/ Daughter 961 North Church Road, Sinking Spring, PA 19608 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town State 16, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 56 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Head & Neck Cancer Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exam Breast Cancer Due to (or as a consequence of) Box 68760 attending physicien Colon Cancer iclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 2□ No 1 ☐ Yes 1 Tes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 XNo 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: , d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62520 May 15, 2006 1401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria D'Arbela, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 327 Registrar's Signature State 16 2006 Registrar

			1 - For State Registrar	State of Mai			nt of He te of D		Mental H	ygiene Reg. No.	2006	17168
П	Physici	e an	1. Decedent's Name (First, Middle, Last	")					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic		Jovan Lewis	Whiting						, 200		1922 M
	Examir	er	4a. Facility Name (If not institution, give					ocation of Death	1		County of Death	
			Southern Marylan 5. Social Security Number 6. Se		(la usa la at himb da)		inton eriyear I	f Under 24 Hrs.	T 0 Date of D		rince Ge	
	Funeral Director			X 2 F	(In yrs. last birthday) 13 Yrs.	Months		Hours Min.	8. Date of B (Month, D July 1	Day, Year)	9. Birthp Cour	place (State or Foreign
			Usual Residence of Decedent						Dury 1	7,1992	z wasni	ington,D.C.
	how	_	10a. State 10b. County		10c. City, Town or Lo	ocation			-		1	0d. Inside City Limits
	Ma-f-	cto	Maryland Prince G	eorges	Clinton							11∑ Yes 2 □ No
	or 2	Dire	10e. Street and Number			10f. Z	ip Code			10g. Citize	en of What Cour	ntry?
	ath v	Funeral Director	5827 Barnes Dr.				20735				ited Sta	
	ttem trem	nue	11. Marital Status 1 ★Never Married 2 Married	12. Was Decedent Ev Armed Forces?		Was Dec If Yes, sp	edent of Hispa ecify Cuban,	anic Origin? (S) Mexican, Puerti	pecify Yes or No Rican, etc.)	lo- 14	 Race - Americ Black, White, 	
5	irs aff	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 🗆 Yes	2₩ No 3	Specify:		s	Specify: Blac	:k
9500-61212	filed within 72 hours after death with the Maryland Hygiene. Ither then "netural", or iteme 23a or 28a-f ehow ent, the Medical Examinar must be notified at	Completed	15. Decedent's Edu	ucation	16a. Dece	dent's Us	ual Occupation	on ,		16b. Kind	d of Business/Inc	dustry
2	B. an "m	pie	(Specify only highest grad	Cottege (1-4or 5+)	(Give	DO NOT	ork done duri use retired)	ing most of wor	king			
7	A Company	S	7th		Sti	ıdent					N/A	
	d oth	Be	17. Father's Name (First, Middle, Last)				18	3. Mother's Nam		e, Maiden S	umame)	
<u>X</u>	ould Men harks	J.	Efren Calungcagi					Paula V				
Maryland	12 sh h and 7 la n traun	1	19a. Informant's Name/Relationship (T) Paula Whiting/ Me					Number or Ru • Clinto		ber, City or 1 2073	Town, State, Zip	Code)
o,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avent, the Medical Examinating any page.		20a. Method of Disposition					T	Date		ation - City or To	wo State
altimore,	ages nt of t: If it f or o		1 Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo	_		Morr				WII, State
	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Resurre						on, Md.	
ñ	Dep Period		1. 1//	0-0101085	- 1	11exa	nder	ro Pike	Funera	l Home	s, P.A.	20747
			23a. Part I. Enter the disease, or comp	lications that caused th	ne death. Do not ent						,	Approximate
	Physician		Immediate Cause (Final	ne cause on each line.	RATOR							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	consequence of):	4	AICU	126				
	Examiner			ASP	IRATIO	N						
	B ==	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							
	nd	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.								
Š	e exe	1 EX	resulting in death) Last	Due to (or as a	consequence of):							
38760,	ficate be executed physicien and is the burial-transit	dical		d							-	
_	leath certific attending p		IF FEMALE:	23c. If yes, outcome of	preggaage							
. Box	death certif e attending ad for use as	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at tir	Fetal death 3	Ectopic p	oregnancy			23	 d. Date of delive Month 	ry Day Year
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ne or death 3	J Other (S	рөспу)					
-	\$ 6 €		Part II. Other significant conditions co	ntnbuting to death but	not resulting in the u	nderlying	cause given i	n Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
	n sign	d by	CEREBRAL	PALSY					1 🗆	Yes 2	No 3 Proba	ably 4 Unknown
8	tw require s been sig	Completed							24a. Was	s an	24b. Were autor	osy findings available
2	The la te ha: age 2	шо								ormed?	prior to con death?	rpletion of cause of
<u>a</u>	sician: The law s certificate has b lirector, page 2 s	BeC	25. Was case referred to medical				26	6. Place of Deal	1 ☐ Yes	2. No one)	1 🗆 Yes	2 L No
>	Physician: r this certifica ral director, I	ToB	examiner?	lospital: 1 Inpatient	2 ER/Outpatier	t 3 D	Other				☐Other (Specify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time of		28c. Injury at Work?		28d. Describe			<u></u>
<u>o</u>	uttendii death. ctor: A y the fu	atic	2 ☐ Accident investigation			М		2 □ No				
Division of Vital Records,	after deatl after deatl Diractor: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, facto	ry, office		28f. Location City or To	(Street and I wn, State)	Vumber or Rural	Route Number,
ב	Hospital or Attending 24 hours after death. Funeral Diractor: Atte tely filled in by the fune		COn Contillor									
	To the Hospitat within 24 hours a To the Funeral t completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of oner: On the basis of example and manner state	camination and/or in	occurred vestigation	at the time, on, in my opinion	date and place, on, death occur	and due to the red at the time.	cause(s) ar , date and pl	nd manner as sta ace, and due to	ated. the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manifer State	u.	29	c, License nu	ımber		29d. Date 4	signed (Month, L	Day, Year)
	⊢≯⊢ŏ		10000				D 40					
0	0		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Tune	Print)					12,200	
K	(3)		TERROY A. JODRI	E, MD.	75 BB S	URR	ATTS	ROAD	CLIN	Tow. A	MARYLA	N
467	Sta		31. Date filed (Month, Day, Year)	. Registrar's	Signature /	<i>M</i> .	•		1			
	Registr	ar	MAY 1 6 2006	Elder	15 Age	W						

			1 - For State Registrar	State o	f Marylar	-	artment rtificate			and Me		giene Reg. No.	006	17169
	Dhusisi		1. Decedent's Name (First, Middle, La								2. Date of De	athDay	Year	3. Time of Death
	Physici /Medic		William Be	rnard	White	Jr					Month 05	10	2006	2:30p M
	Examin		4a. Facility Name (If not institution, give				4b. City, T						County of Death	
	Ast		1308 Summit						tead				Carrol	
3	Funeral			Sex XΩM 2□F	7. Age (In yrs.		If Under 1 Months	Days	Hours	Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent			<u>T</u> 115.				(07-30-	-194	4	PA
	and w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary	ŏ	MD Carr	011		Hamps	tead							1 ☐ Yes 2 ☑ No
	128a	9	10e. Street and Number				10f. Zip C	Code				10g. Citiz	en of Whal Cou	ntry?
	38 o	0	1308 Summit	Street				210	74				USA	
	deet mms 2	by Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Decede	enl of His	spanic Orig	gin? (Spec	cify Yes or No-	- 1	4. Race - Ameri	
9	after or Its	臣	1 ☐ Never Married 2 ☐ Married	1 D Yes		67-	1 ☐ Yes 2		Specify:	, rueito n	noan, etc.)		Black, White,	etc.
21215-0036	Jral',	d b	3 Widowed 4 Divorced	Year or D	ates: 19	69	103 2	-2K140	Specify.				Specify: W	hite
2	filed within 72 hours after deeth with the Maryland Hygiene. Yther than "natural", or Items 23a or 28a-f ehow ent, the Medical Exam. ar must be rediffed at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	lent's Usual kind of work	done di	urina most	of working	g	16b. Kir	nd of Business/In	dustry
12	withir ane. Ithan	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use Custo						Cleani	n o
р П	filed Hygir ther	ပ္သ	17. Father's Name (First, Middle, Last)						r's Name	(First, Middle,			119
ylan	Mental Mental arked o	To Be			White,	Sr				roth			agle	
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ē,	is 1 and 2 of Health ar Item 27 is other trau		20a. Method of Disposition		20b. F	Place of Dispo cometery, crei	sition (Name	e of		Da			ation - City or To	
Ë	Page ent o nt: If ry or		Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			rison Fo	rest Ve			5-15	5-06	Owi	ngs Mi	lls, MD
alti	mit. pertm porta / Inju		21. Signature of Funeral Service Lice	nsee		Cemet	. Name and	Address	of Facility	/ m 1 4	-		al Home	
m	Depermine Depe		Khilles XI	ach	 MOO5	50 9.	34 S.	Ma	in S				d, MD	
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<u></u>				-							1 Yes	2 No	1 🗆 Yes	2 No
₹	ysician: The is certificate he director, page	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		50/0		Other	r+		Check only or			
o	Phys r this ral di	.: To	27. Manner of Death			28b. Time of		`	4 🗆 Nui	sing Home	e 5 Resid		Other (Specif	y)
o	th. Afte	tior	1 Natural 5 Pending 2 Accident investigatio		of Injury th, Day Year)	Injury	м	c. Injury : Work?	? es 2 □ N				30041.00	
Division of Vital Records,	Attending Physician: or death. ector; After this certifice by the funeral director; g	ertification:	3 Suicide 6 Could not b	e 28e. Place	of Injury - At h	ome, farm, str	eet, factory, o	office		28	St. Location (S	Street and	Number or Rura	al Route Number,
<u></u>	after after I Dire	ert	4 Homicide determined	buildi	ng, etc. (Specif	y)					City or Tow	m, State)		
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Pl	nysician: To the	best of my kno	wledge, death	occurred at	the time	, date and	place, an	d due to the c	ause(s) a	and manner as s	tated.
	the H the F the F		(Check only 2 Medical Exalt one)	and mani	ner stated.	mon and/or m	restigation, in	п ту орг	nion, dear	n occurred	at the time, c	date and p	place, and due to	the cause(s)
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	MJ		30. Name and address of person who	/			•							7-1-1-1-1
			31. Date filed (Month, Day, Year)	uma	gistrar's Signa	l W. Be	elvede	re A	ve. I	Balti	more M	D 21:	215	
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			For Stata Registrar	State of Maryland		artment of H rtificate of L			iene2 () () 6	1/1/0
	Dhuaiai		Decedent's Name (First, Middle, Last)					2. Date of Deal	th	3. Time of Death
	Physici /Medio		Ruth Yvonne Wal					May 15	5, Day 2006 ear	10:45ам
1	Examin	er	4a. Facility Name (If not institution, give s 3 Glymont Road	· ·		4b. City, Town, or Indian	Location of Death		4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	0.8:4	nplace (State or Foreign
	Director		370-70-0432	IM 2XIF 56	Yrs.	Months Days	Hours Min.	Oct. 2	25,1949 W	nplace (State or Foreign untry) asingtonD(
	land DW		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary Feh	ţo	Maryland Charl		dian					1 XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	untry?
	death with the Maryland ms 23a or 28a-f ehow mast te natified at	ral	3 Glymont Road			206			U.S.A.	
350	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23s or 28s-f show event, it a Medical Exatilities must be multiplial	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	1	Was Decedent of His f Yes, specify Cubar 1 □ Yes 2 🔀 No	spanic Origin? (Spen, Mexican, Puerto l Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	72 hor	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occupa	ition	20	16b. Kind of Business/I	ndustry
7	filed within 72 Hygiene. Ither then "net ent, the Medic	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done d OO NOT use retired)	uning most or working	ng		
7	filed v Hygie ther t	CO	17. Father's Name (First, Middle, Last)		Purc	chaser	18. Mother's Name	(First Middle A	U.S. GOV	ernment
<u>a</u>		To Be	Carl Eugene Pri	ce, Sr.					Wright	
ary	2 should and Men le marke sumatic	-	19a. Informant's Name/Relationship (Type	oe, Print)			nd Number or Rura	/ Route Number,	City or Town, State, Zi	
	s 1 and 2 should I Health and Mer Item 27 le marke other traumatic		Horace Waldbaue						ad, Md. 2	
Baltimore,	permit. Pages 1 Depertment of H Importent: If Ite any Injury or ot ance.		20a. Method of Disposition 1 SpBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Pis		sition (Name of natory or other place Nazarene			Pisgah, I	
Dall	permit. Depert Import any Inj		21. Signature of Funeral Service License	мооб	4	Name and Address Villiams 1270 Hāw	thorne I	Rd. Tr	ndian Head	20640
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	ations that caused the death e cause on each line.	. Do not ente	er the mode of dying	, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
d	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Colon Cov	ncer					Onset and Death
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	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
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XOD	death certificate be executed e attending physician and ad for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan		Ectopic pregnancy			23d. Date of deliv	
	the deay y the a	Physician/M	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4☐Pregnant at time of dea	ath 5□	Other (specify)			Month	Day Year
κ, Γ	requires that the neen signed by th hould be detache	by P	Part II. Other significant conditions con	inbuting to death but not resul	lting in the un	iderlying cause giver	n in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ecords,	equire	ted						1 ☐ Ye	s 2. No 3 □ Prol	bably 4 Unknown
ဋိဋ	law as b 2 s	Completed						24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
7	n: The ficate hi or, page	e Co	OS Was associated to madical						X No 1 ☐ Yes	2□ No
5	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	B/Outpatient		26. Place of Death		nce 6 □Other (Specia	
5	ng Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1	28b. Time of Injury	28c. Injury			w injury occurred	9)
<u> </u>	tendir eath. for: Af the fu	catlo	2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y	es 2 □No			
DIVISION	tal or At rs after d al Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office	2	8f. Location (Street) City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edlcal	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the time estigation, in my opi	a, date and place, a nion, death occurre	nd due to the car d at the time, da	use(s) and manner as s te and place, and due to	stated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	6		29c. License			d. Date signed (Month,	Day, Year)
			1' 1/1/1/1/1/	6		D464	119		5/16/06	
0	0016		30. Name and actions of person who con Churlene A Letchforn	mpleted cause of death (Item :	23a) (Type, F Charl	erint) St L	a Plata,	MD 20	064b	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 20	32. Registrar's Signatu	ııe	acht y				

			For Stata Ragistrar	State of Ma	aryland / Dep <i>Ce</i>	artment of Fertificate of		ental Hygie Reg.	4000	17171
	Dharaini		Decedent's Name (First, Michael	ddie, Last)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		GERTRUDE WHIT						14 200	6 $10:55 P^{M}$
	Examir	er	4a. Facility Name (If not institut				or Location of Death		4c. County of De	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday			8. Date of Birth (Month, Day, Ye	QUEEN 9. 8	lirthplace (State or Foreign
	Director		233-34-4403 Usual Residence of Decedent	1 □ M 2 💢 F	83 Yrs.	Months Days		MAR. 21,		Country) TV
land	Mon I		10a. State 10b. Cour	nty	10c. City, Town or L	ocation				10d. Inside City Limits
e Man	if self si	ctor	MD QUE	EN ANNE'S	CHESTER					1 ☐ Yes 2 🗶 No
vith th	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What (Country?
eath v	ns 238	Funeral	401 SWAN COVE	E LANE 12. Was Decedent	Ever in U.S. 13	21619	lispanic Origin? (Spe		SA 14 Bace An	nerican Indian,
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within 2	then then	duic	Elementary/Secondary (0-12	2) College (1-4or 5	5+)	DO NOT use retire	,	1	EDIICATTAI	ar.
מ פווייי	othar vant, I	0	17. Father's Name (First, Midd	le, Last)	FINE	MCIAL CLI	18. Mother's Name		EDUCATION iden Sumame)	N
arylar should b	and Mental Hygiene. is markad othar then aumatic evant, the M	ToB	JERRY WATSON	CRISS			ICES R.	RIGGINS		
(1			19a. Informant's Name/Relation				and Number or Rural			, Zip Code)
	f Heali tam 2 other		20a. Method of Disposition	. / DAUGHTER	20b. Place of Disp	osition (Name of	LANE, CHE		21619 c. Location - City of	or Town, State
altimore,			1 X Burial 2 ☐ Crematio 1 4 ☐ Donation 5 ☐ Other	on 3 Removal from State (Specify)		matory or other place CEMETER		/2006 K	INGWOOD,	wv
Balti Permit.	Department Important: If any Injury or 900ce.		21. Signatur of Fundal Sovy	Licensee	2	2. Name and Addre	ss of Facility			HOME, P.A.
г			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that caused ist only one cause on each line	the death. Do not en	iter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	A -	e rend	Kilne	4			3 Week
	Medical xaminer		resulting in death)		a consequence of):	- 1 0				
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8760, sate be exe	ician a burial-		resulting in death) Last	Due to (or as	a consequence of):					
	s the	edical		d						
ecords, P.O. Box (aw requires that the death certif	attending for use as	In/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
O. Be death	the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
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ecords, law requires t	been signed b should be deta	d by	, 2	The state of the s	at the trade and the trade	indenying cause giv	orriiri aitti.	1 ☐ Yes	. <i>i</i>	Probably 4 Unknown
	s beer shou	olete						24a. Was an	24b. Were a	autopsy findings available
E 2	page 2	Completed						autopsy performed 1 ☐ Yes 2 🛣	death?	completion of cause of
Vital Vician:	certificate rector, pag	Be	25. Was case referred to medi examiner?	and the same of th		150	26. Place of Death			EHTERS.
Of Phys	r this cral dir	7: 10	1 Yes 2 No	Hospital: 1 Inpatie			4 Nursing Hom	e 5 Residence	e 6 SOther (Spi	ecity) Hme
lon Iding	ath. r: After e funera	ation	1 Naturaf 5 ☐ Pend		Year) Injury	Wor	k? Yes 2 □ No	54. D0301100 11044 11	illary occurred	
DIVISION OF	ractor: A	Certification;		Id not be 28e. Place of Initial building, etc.	ury - At home, farm, st	reet, factory, office	28	8f. Location (Street City or Town, St		Rural Route Number,
	urs aft arel Di									
DIVISION OF VITA To the Hospital or Attending Physician:	within 24 hours after death To the Funarel Diractor: completely filled in by the	Medical	(Check only 2 Medic one)	ying Physicien: To the best of al Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occurred	nd due to the cause d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Tot	To	2	29b. Signature and title of certification	lier		29c. Licens		29d.	Date signed (Mon	
			30. Name and address of person	Dim m	oath (fton 22s) (T	D41	339	M	14 15	2006
5	KK		Jam & Harm				TEVENJV	LLE N	vs 2/66	4
	Sta Registr		31. Date filed (Month, Day, Yea		s Signature	Sparke			,	
						-				

			1 - For State Registrar	State of Ma			ent of He <i>ate of D</i> e		Mental H		2006	5 17178
			Decedent's Name (First, Middle, La	st)			4.0 0, 5		2. Date of D			3. Time of Death
	Physici		Ozzie A. Wil	liame Tr					Month	Day 13	_{Уваг} 2006	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. C	ity. Town, or Lo	ocation of Deat	May		ZUU6 County of Dea	16:50 M
	Exami	iei	Southern Mar		ital			inton	.,		,	
	Funeral		5. Social Security Number 6.5	·	в (In yrs. last biri	hdav) If Un		ITLOII If Under 24 Hrs	8. Date of B			George's
	Director			™ 2□ F		rs. Mont	hs Days	Hours Min.	July 2	ay, Year)		thplace (State or Foreign buntry)
			Usual Residence of Decedent						July 2	192	o Nor	th Carolina
	yland		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maria	ō	Maryland Prince	George's			M-	itchell				1 X Yes 2 No
	1 288	Director	10e. Street and Number	George 5	1	10f.	Zip Code	Trement	ville	10g. Citiz	en of What Co	ountry?
	3a o		1704 Sycamore	Heights Co	urt			20721		_	IInd+od	States
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other then "natural, or items 23a or 23s-f show or other traumatic event, the Madical Expuritment must be incitified at	Funerai	11. Marital Status	12. Was Decedent		13. Was De	cedent of Hisp				4. Race - Ame	
0	r ite	Fur	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ X	No			Mexican, Puer	ipecify Yes or No to Rican, etc.)		Black, Whit	
ğ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	s 21XNo	Specify:			Specify:	American
Ą	2 hou	Completed	15. Decedent's E		16a.	Decedent's U	Jsual Occupation	on		16b. Kin	d of Business/	
2	n n	pie	(Specify only highest gr			(Give kind of life. DO NO	work done duri Tuse retired)	ing most of wo	rking			,
212	The least	E	Elementary/Secondary (0-12) 12th	College (1-4or 5	1+)		Guard	_			Govern	mont
D	filed Hygie other	BeC	17. Father's Name (First, Middle, Last						ne (First, Middl	e, <i>Maid</i> en S		ment
Maryland 21215-0036	d be ental ked c	To B	Ozzie A.	Williams,	Sr.				Nea	ly Du	nn	
<u> </u>	should nd Men marke umatic	-	19a. Informant's Name/Relationship (Mailing Addr	ess (Street and	d Number or Ri				Zip Code) 20721
S	d 2 in the art traut											
o,	1 and Health em 27 Ither tr		Elaine P. Will:	lams/wile	20b. Place of			нетупт	S Court		Chellvi ation - City or	111e, MD
کّ	Pages nent of ant: if it		1 XBurial 2 ☐ Cremation 3 ☐		cemeter	v, crematory o	or other place)			200. 200	ation - Oity of	TOWN, State
₽	tent tent		4 □ Donation 5 □ Other (Special		Cedar	1	Cemete	-	0/2006		uitland	
Baltimore,	permit. Pages 1 ar Department of Hea importent: if Item eny injury or othe once.		21. Signatur of Funeral Service Lice	T T	10	22. Name	and Address		tewart		al Home	
	70 = 0		John .	Mewan		1			ng Rd.,		Wash.,	DC 20019
П			23a. Part 1. Enter the disease, or com shock of heart failure. List only	plications that caused one cause on each lir	the death. Do n	ot enter the n	node of dying, s	such as cardiad	or respiratory	arrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	50	04	, _						Onset and Death
ļ.	/Medical		resulting in death)	Due to (or a	a consequence of	(f):	70	<u>«</u>				
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98/60	ficate be executed physicien and is the burial-transit			d								
89	= 0.4	edicai										
×	The law requires that the death certif te hes been signed by the attending page 2 should be detached for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					22	ld. Data of dali	uon.
ROX	atter for u	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic 5 ☐ Other	pregnancy (specify)			23	ld. Date of deli Month	Day Year
o	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		0 0 0 0 0 0	(0,000,17)					
<u> </u>	that the de ned by the a detached		Part II. Other significant conditions of	ontributing to death by	ut not resulting in	the underlyin	a cause aiven i	in Part I	23e Did	tobacco usi	a contribute to	the cause of death?
Vital Records,	sign d be	1 by		-		,	g			Yes 2		bably 4 Tunknown
Ö	w require been si should t	ete								100 24		
ě	slaw nest e 2 s	id u							24a. Was	psy	24b. Were au	topsy findings available completion of cause of
<u> </u>		Completed							1 Yes	ormed?	death?	2□ No
<u>I</u>	Attending Physician: 1 r death. ector: After this certificat by the funeral director, p.	Be	25. Was case referred to medical examiner?				26	6. Place of Dea	th (Check only	one)		
	hysic Disco	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER/Out	patient 3	DOA Other:	4 Nursing H	ome 5 Res	idence 6	☐Other (Spec	ufy)
0	ding Ph n. After th funeral		27. Manner of Death 1 ♣ Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)		me of jury	28c. Injury at Work?		28d. Describe			
<u> </u>	uttendir death. ctor: Al y the fu	atic	1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation			М		2 □ No				
DIVISION OF	ar de	5	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of Inju	ry - At home, far	m, street, fact	tory, office		28f. Location	Street and	Number or Ru	ral Route Number,
5	Hospital or Att 24 hours after de Funerei Direct letely filled in by t	Certification:		building, etc	· (abacity)				City or 10	wn, State)		
	Hospital 24 hours 2 Funerei 1 tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge,	death occurr	ed at the time,	date and place	, and due to the	cause(s) a	nd manner as	stated.
	P Fu	edicai	(Check only 2 Medical Exar	niner: On the basis of and manner sta	examination and	or investigati	ion, in my opini	on, death occu	rred at the time,	date and p	lace, and due	to the cause(s)
	To the within 2 To the complet	¥	29b. Signature and title of certifier		/ ,	1	29c. License nu	umber		29d. Date	signed (Month	, Day, Year)
			MALALLA	1/21/	- /	mo	1000	36/			(-)	1.1.1
0	(/_)		30. Name and address of person Ways	completed cause of de	A CHANGE	////	- 3 7	7	•		-1/	5/06
14	10/	İ	30. Name and address of person Voya	A DA	fath (Item 23a) (ype, Print)			er, M.D		•	
	Sta	• 0	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		7503	Surrats	Road,	Clint	on, MD	20735
	Registr		MAY 1 8 2006	Beach	K la	antis						

		4	For State	State of M	aryland		rtment of H tificate of	leaith and N <i>Death</i>		giene 2 ()	06	17173
			Registrar 1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath		3. Time of Death
	Physicia	ın	Edna Jane W						Month		Year 006	12:45A ^M
	/Medic		4a. Facility Name (If not institution, give		r)		4b. City, Town, o	or Location of Death		4c. County of		+201,321
	Examin	er	Southern Mar					Clinton	n	Prin	ice G	eorge's
	Funeral		5. Social Security Number 6.5	Sex 7. A	ge (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.				ace (State or Foreign
	Director		256-54-6334	1□ M 2□XF	68	Yrs.	Monins	Tiours INIA.	Mar. 16			n Carolina
3	2		Usual Residence of Decedent		10a Cibe	Town or Lo	ontion				10	d. Inside City Limits
	who a	_	10a. State 10b. County		Toc. City,	10wil of Lo	Cation				1	1 X Yes 2 □ No
2)- ea	Directo		George's			10f. Zip Code	Landover		10g. Citizen of W	hat Count	rv?
4	0.2	吉	10e. Street and Number				TOIL ZIP COUR	20785				
	23	a l	7207 Greele	y ROad 12. Was Deceder	at Ever in U.S	13. \	Was Decedent of	Hispanic Origin? (Sc	pecify Yes or No		- America	tates In Indian,
9	lal Hygiene "lead with 12 flours are resent with the manyears tal Hygiene "de other then "natural", or iteme 23s or 28s-f show event, the Medical Exerciper must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? X No		fYes, specify Cub 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto	Rican, etc.)	Specify:	c, White, e	ıc. ack
5-0036	tural		15. Decedent's E		,. 	16a. Deced	ient's Usual Occu	pation		16b. Kind of Bu	siness/Ind	ustry
<u>.</u>	then "na"	et	(Specify only highest gi	rade completed)	.5.)	(Give	kind of work done DO NOT use retire	during most of world)	king			
21:	the state of the s	Completed	Elementary/Secondary (0-12)	College (1-40	r 5+)		Cot	inselor		Pri	ivate	
ָ כ	Hygi other	BeC	17. Father's Name (First, Middle, Las	(t)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame	3)	
<u>a</u>		To B	Alfre	d Mobley				A.	llean Ha	rdy		
Maryland	E E E		19a. Informant's Name/Relationship			19b. Mailir	-	t and Number or Ru				_
	end 2 leath a m 27 le		Crystal Williams	/Granddau				7th St.,			2070	
ġ.	1 2 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta	te ce	metery, crer	sition (Name of matory or other p		Date	20c. Location -	Sity or Tov	vn, State
Ĕ,	rages nent of ant: if it ury or o		4 □ Donation 5 □ Other (Spec		Sto			ch. 5/2			ken,	SC
Balti	permit. Pages Department of important: if it eny injury or one		21. Signature of Funeral Service Lice	The sant	ITT	22	2. Name and Addr 400	ess of Facility S Benning		Funeral Wash.,		20019
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caus	sed the death	. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition		Anoxi	1. 6	niebki	pothe				Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequ	ence of):		1	,	0		
	Examiner		Sequentially list conditions,	b. Cor	dio p	nlmoi	rall a	ries -	prolong	ed asyst	ek.	
	D ==	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ience of):		d = 22				
	icate be executed physiclen end s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	lence of):	arreves	- 011 Sea	re			
8760,	clen			200.0 (0.0		0	0					
87	physicate physicate	dicai	3	d								
× 6	ding	/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnar	ncy				23d. Date	e of delive	ry
Вох	The law requires that the death certific site has been signed by the ettending p page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal t at time of de		∃Ectopic pregnan ∃ Other (specify)	су		Mor	ith	Day Year
P.O.	thet the de ned by the e detached f	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknowr								_
σ.	thet	y P	Part II. Dther significant conditions	contributing to deat	h, but not resu	ilting in the u	inderlying cause g	iven in Part I.	23e. Did 1	obacco use contr	ibute to the	e cause of death?
g	surres n signe	D D	Ischemic	- ACW	alh	Ville	N hec	10505	1 🗆	Yes 2□No	3 🖺 Proba	ably 4 □Unknown
Vital Records,	s been si should	Completed	Advill- Coshi	rally 0	distre	188	sund	me_	24a. Was	an 24b. V	Vere autop	osy findings available inpletion of cause of
æ	The is	Ę	Anim alak	Molon	14/11	. 77	- Nd wa	300	perfo	rmed?	leath?	
	en: T	0	25. Was case referred to predical	_) - 14 Vac	VV USE		18 (0)	26. Place of Dea	ath (Check only	-Ar		
>	ysicions ser	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Unp	atient 2 🗆	ER/Outpatie	nt 3 DOA	ther: 4 🗆 Nursing H	fome 5 ☐ Resi	dence 6 Oth	er (Specify)
0	Attending Physicien: r death. sctor: After this certific by the funeral director,		27. Manner of Death	28a. Date of I	njury Day Year)	28b. Time o	of 28c. Inj	ury at ork?	28d. Describe	how injury occurr	ed	
ō	ath. Tage	atio	1 Accident 5 Pending investigat	tion	<i></i>			∃Yes 2⊟No				
Division of	l or Atte efter de Diracto I in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Place UI	Injury - At ho etc. (Specify	ome, farm, st	reet, factory, offic	9		Street and Numb wn, State)	er or Rural	l Route Number,
0	ral D			***************************************	102020000000000000000000000000000000000	near are			a soul door to the	and a state of the	move ar et	ah ali
	To the Hospital or Attending Physicien: The lawithin 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, pege 2	Medical	29a. Certifier Check only 2 Medical Ex	Physician: To the beaminer: On the basi and manner	s of examinal	wiedge, deal tion and/or in	nvestigation, in my	opinion, death occu	urred at the time,	date and place,	and due to	the cause(s)
	othe vithin i	Me	29b. Signature and title of certifier	4/11/	Ar	nitSu.	29c. Lice	nse number		29d. Date signed	(Month, I	Day, Year)
	->		> Mull	1911/	^	10	bo	2062.	200	5/15	-/2	006
Λ	(2)		30. Name and address of pers 30	to completed cause	of death (Item	1 23a) (Type	, Print)				-1-	
1	101		Amit Suri					linton, M	D 20735	5		
		ate	31. Date filed (Month, Day, Year)	R2 Rec	istrar's Signa	ture						
	Regist	rar	MAY 1 8 200	6 Alexa	J. J.	Great	W					

			For State Registrar	State of M	-	-	ent of H		and Mental F	lygiene Reg. No. 2	006	17171
	Physicia	.,	1. Decedent's Name (First, Middle, Las	it)					2. Date of Month	Death Day	Year	3. Time of Death
	/Medić		Doris Lee White						May 14	, 2006		630AM
	Examin	er	4a. Facility Name (If not institution, give				City, Town, or		of Death		unty of Death	
	Firmanal		216 S. Mont Valla 5. Social Security Number 6. S		je (In yrs. last birtl		gerstov	/II If Under:	24 Hrs. 8. Date of	Rirth	shingto	olace (State or Foreign
L	Funeral Director			□ M 212 F		rs. Mon	ths Days	Hours	Dec.	3, 1919	9 West	Virginia
	yland how		10a. State 10b. County		10c. City, Town	or Location					1	10d. Inside City Limits
	e Ma	cto	Maryland Washingt	on	Hagers	town						1 res 2 □ No
	with the	Directo	10e. Street and Number			101	. Zip Code				of What Cour	ntry?
	eath y	eral	216 S. Mont Valla	12. Was Decedent	Ever in I.I.S.	13 Was D	21740	snanic Ori	gin? (Specify Yes or	U.S.A.	Race - Americ	can Indian
36	d within 72 hours after death with the Maryland piene. Ir then "neturel; or Items 23e or 28e-f show The Medical Examiner must be rediffed at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	/		specify Cuba		gin? (Specify Yes or i, Puerto Rican, etc.)		Black, White,	etc.
9	ture!		15. Decedent's Ed	Year or Dates:	16a. I	Decedent's	Usual Occupa	ation		16h Kind (of Business/In	
21215-0036		Completed	(Specify only highest gra	de completed) College (1-4or		(Give kind o life. DO NO	f work done d T use retired,	luring mos:	t of working	TOD. Raid	7 Dusinessan	dustry
212	e filed within at Hygiene. I other then 'vent, the Me	Com	12	College (1-40)		rsing	Aid			Heal	Lth Car	ce
Maryland	ges 1 and 2 should be filed it of Health and Mental Hygis ! If item 27 is marked other or other treumatic event, [Be	17. Father's Name (First, Middle, Last)						r's Name (First, Midd		name)	
<u> </u>	2 should be to and Mental I is marked or reumatic ever	To	Charles E. Knadle		401	has title at a large	(24		rrie Mae I			
Ma	d 2 st th an t7 is r treur		Donald L. White			-			ur or Rural Route Nur			
	of Health of Health item 27 i	decimal (25)	20a. Method of Disposition		20b. Place of	Disposition			Hagersto Date		on - City or To	
OE	Pages nent of l int: If it		1 ☐Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		Rest Ha	-			lay 17 200	6 Hager	stown l	Marvland
Baltimore,	permit. Pages Department of I Importent: If its eny injury or or	Ì	21. Signature of Funeral Service Licen	5807					Rest Hav			
<u>m</u>	88 = 88		1 mm h/	1-)	1601	Penns	y1van	ia Ave Ha	gerstow	n Mary	land 21740
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, of com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a bue to or as	a consequence o	العد ن ا	10 5	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
,8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence o	f):						
P.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectop 5 □ Othe	ic pregnancy (specify)			23d.	Date of delive Month	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlyi	ng cause give	n in Part I.		tobacco use o		ne cause of death?
Vital Records,	The la ate has page 2	Completed	, ,						24a. Wi au pe 1 Yes	opsy formed?	prior to cor death?	psy findings available mpletion of cause of
Zi Zi		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Out		Othe		of Death Check onl			
o	Physer this eral di	\vdash	27. Mann Death	28a. Date of Inju	ry 28b. Ti	me of	28c. Injury Work	4 🗆 140	rsing Home 5 The 28d. Describ	sidence 6 ∐i e how injury oc		/)
ion	Attending Ph ir death. ector: After th by the funeral	atio	1 atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear) In	jury M		? ′es 2 □ N	No			
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of inj	ury - At home, farr c. (Specify)	m, street, fac	ctory, office			(Street and Nuown, State)	imber or Rura	l Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	f examination and	death occur or investiga	red at the time tion, in my op	e, date and inion, deat	d place, and due to the h occurred at the time	e cause(s) and e, date and plac	manner as st ce, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	3			29c. License	number		29d. Date sig	ned (Month, I	Day, Year)
•			freder 1	1- 1	(11)	FA	17	376	23	men	15	7006
5	H-5		30 Name and address of person who	completed cause of c	leath (Item 23a) (T	ype, Print)	NOV	red	red Con	ous k	Ed	
:-	Sta Registr		31. Date filed (Month, Day, Year) MAY 172	32. Registr	ar's Signature	Sperk	e e			teger	time.	i lm A
-												

5

		Please I	ype or Print				•	•	
		1_ For State	State of Mary				lental Hygi	ene 2 0 0 8	5 17 175
		Registrar		Ce	ertificate of	Death	Reg	. No.	
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
/Medic		Juanita Ethel	Wolfensber	ger			WAY	5 2006	(0°, 37 A M
Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	(4c. County of Dea	th
		Washington Cou	nty Hospit	al	Hager				on County
Funeral		5. Social Security Number 6. Sex	7. Age (li]M 2√ □F	n yrs. last birthdaj	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign ountry)
Director		219–12–0305 Usual Residence of Decedent		82 Yrs.			April 30) 1924 N	Maryland
and wo		10a. State 10b. County	10	c. City, Town or I	Location				10d. Inside City Limits
Mary	ō	Maryland Washing	tton	Нэс	erstown				1X Yes 2 No
1he	rec	10e. Street and Number	,com	nay	10f. Zip Code		100	J. Citizen of What Co	ountry?
3a or	Funeral Director	310 Opal Court				21740		U.S.A.	
me 2	era		12. Was Decedent Eve	r in U.S. 13	. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Race - Amo	
or te		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	,			Rican, etc.)	Black, Whi	te, etc.
Error	þ	3 X Widowed 4 □ Divorced	If Yes, Give 12 Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
72 hc	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dec	edent's Usual Occup	ation	16	b. Kind of Business	/Industry
thin a	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	re kind of work done of DO NOT use retired	d)	g		
ygier ygier t,	Co	6			Caregiver				on on Aging
d of H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	uiden Sumame)	
Men Men Merke Marke	Jo	Harry Molinari						gan Fisher	
2 sh and ts m		19a, Informant's Name/Relationship (Ty	pe, Print)	19b. Mai	ling Address (Street	and Number or Rur	al Route Number, (City or Town, State,	Zip Code)
and leelth m 27 her t		Glenda J. Geris		269	Shacklefo	ord Well	Rd. Frede	ricksburg	VA 22406
Fite	1	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R		cemetery, cr	ematory or other plac	(e)	Date 20	c. Location - City or	Town, State
tant:		4 □ Donation 5 □ Other (Specify)			wn Cemete:	_ ,		unkstown	_
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-f show ent injury or other traumatic event, the Medical Examinat must be notified at 90ce.		21. Signature of Fun eral Service License	- Pauley	TR.	22. Name and Address 1331 Easte	ss of Facility Do ${\sf ern}$ Blvd.	uglas A. N. Hager	Fiery Fur	neral Home yland 21742
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
Physician	20	Immediate Cause (Final disease or condition	^	RATORY	FALURE				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co						
Lxammer	_	Sequentially list conditions,			INOU BLE	ED			
pe #s	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
be executed icien and burial-transli	Examin	that initiated events resulting in death) Last	Due to (or as a co		ILURE				
e be executed /sicien and e burial-transit	al E		4105						
w requires that the death certificate been signed by the ettending phys should be deteched for use as the	0			72	TURE				
ding re as	Physician/Medi	IF FEMALE:	3c. If yes, outcome of p	regnancy				224 2-14	P
eath etter for L	clar	in the past 12 months?	1 Live birth 2 □ 4 □ Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	Day Year
y the	ıysı	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
that		Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
puires	Completed by	ATRIAL FIB	21LLMON				1 ☐ Yes	2 □ No 3 □ Pi	obably 4 Unknown
shou	lete	URINARY TO	2 10.5=	ction			24a. Was an	24h Were as	utopsy findings available
he ta	Ĕ	- 17- 114- 1	PICI INFC	CITOR			autopsy	prior to	completion of cause of
ifficet or. pi	ပိ	25. Was case referred to medical				00 Pl (P		1 ☐ Yes	2□ No
ysicle s ceri	To B	examiner?	ospital: 1 Inpatient	2 ER/Outpatio	ent 3 DOA Oth	or	(Check only one)	ce 6 □Other (Spe	
eral eral		27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe how		cny)
eth. r: Aft	atlo	1 Matural 5 Pending 2 Accident investigation	(Month, Day Ye	nar) Injury		k? Yes 2 □No			
Atte	Hic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	At home, farm, s	treet, factory, office		28f. Location (Stre	et and Number or Ri	ural Route Number,
s after or all Direction	Certification:		building, etc. (5	pecity)			City or Town, .	Siale)	
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be deteched for use as the	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of more: On the basis of exa and manner stated	amination and/or i	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manner as a and place, and due	s stated. to the cause(s)
To the within To the Comp	¥	29b. Signature and title of certifier			29c. License	e number	290	. Date signed (Mont	h, Day, Year)
-		Amar			Dog	06200	5	5/15/0 6	
7		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type		6200		-1-3/0 6	
4.1		De Wiredu	251 Eas	+ Ante	tam Il	. /tra 4	11 21-	140	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1	1			
Registi	rar	MAY 16 20	106 Dane	1. B. K	pull				
MH 17 Rev 1/2	1001			/					

			For State Registrar	State o	f Marylan	d / Depa <i>Cer</i>	irtment o	f Health of Death	and M		jiene2	006	17176
	Physici /Medic		1. Decedent's Name (First, Middle, La: Dorothy	st)	W	einste	in			2. Date of Dea Month May	_	20 06 °	3. Time of Death 6:50A. м
	Examin		4a. Facility Name (If not institution, give Somerford Assiste	street and nu d Livir	mber) 1g		4b. City, Tow Colu	n, or Location Imbia	of Death		4c. Cou HOW	nty of Death ard	
	Funeral Director		120 20-1330	ex □ M 2XF	7. Age (In yrs. 9	last birthday) 3 Yrs.	If Under 1 Y Months Da	ear If Under lys Hours	Min.	8. Date of Birth (Month Day Aug. 9,	912	9. Birthp Cour Broo	lace (State or Foreign Klyn, NY
-	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard			y, Town or Lo Columbi						1	0d. Inside City Limits 1 ☐ Yes 2 🂢 No
	th with the 23a or 28 Ist be not	Funeral Director	10e. Street and Number 8220 Snowden Rive	r Parkv	ay		10f. Zip Co		045		-	of What Cour ed Sta	•
030	filed within 72 hours after deeth with the Maryland Hygiene. the than 'naturel', or items 23a or 28a-f ehow that the Madical Examiner must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2̸No ve		Vas Decedent f Yes, specify			cify Yes or No- Rican, etc.)	14. F	lace - Americ Black, White, cify: Wh	
N-01717	od within 72 ho giene. er then "netu	Completed	15. Decedent's E. (Specify only highest gra		1-4or 5+)	16a. Deced (Give life, L	lent's Usual Oi kind of work di DO NOT use re Ookkee]	ecupation one during mos stired)	st of workin			Business/Ind	age company
/land	uld be file Mental Hy Irked otha	To Be (17. Father's Name (First, Middle, Last, Meyer			Rip	stein	18. Moth Ros		(First, Middle,	Maiden Sum	Dwor	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or items 23a or 28a-1 show environy or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Jerome Weinstein 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	-son		6964 Place of Disposemetery, cren	Sunflection (Name of natory or other	k Row	Colum	Poute Number bia, Ma	ryland 20c. Locatio	d 2104	5 wn, State
Baitim	permit. Pag Depertment Important: eny injury once.		4 Donation 5 Other (Specifical Signature of Funeral Service Lice	1 0 \(\)	Tem	Do	Name and A	dress of Facili	ardt	.5/2006 Funeral ad Belts	L Home	. PA	lorida land 20705
	/Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on A	caused the death each line. Zheimer (or as a conseq	h. Do not ente	er the mode of	dying, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death 2 years
	Examiner and I-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq								
P.O. Box 68	The law requires that the death certificate sie been signed by the ettending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live	tcome of pregna birth 2 □ Feta nant at time of d own	Ideath 3	Ectopic pregn					Date of delive	rry Day Year
rds, r	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to c	eath but not res	ulting in the ur	nderlying cause	given in Part	l.		bacco use co es 2. XINo		ably 4 \(Unknown
al Keco		Completed	25. Was case referred to medical	W							sy med? 2XQ No	prior to cor death?	psy findings available inpletion of cause of
Division of Vital Records,	Attending Physician: The lar death. ector: After this certificete he by the funeral director, page 2	ation: To Be	examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mor		ER/Outpatien 28b. Time of Injury	28c.		ursin g Hon	(Check only or ne 5 Reside 28d. Describe he	ence 6 💥		isted Livin
	ital or Atte	Certification:	3 Suicide 6 Could not be determined	build	of Injury - At ho ing, etc. (Specif	ý) 	***************************************			City or Town	n, State)		l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Medical Example and title of certifier	niner: On the t	e best of my kno easis of examina iner stated.	owledge, death ition and/or inv	estigation, in a	e time, date ar ny opinion, dea cense number	nd place, a ath occurre	ed at the time, d	ate and plac	manner as st e, and due to ned (Month, I	the cause(s)
	7		1 Jane 1 - 1		endri		D2	27394			May 12	2, 200	5
			30. Name and address of person who James Richardson,		se of death (Item 333 Nor Registrar's Signa			reet,#	325 B	Baltimor	e, Mar	cyland	21211
	Sta Registi		31. Date filed (Month Pay, Year)	.006	Registrar's Signa	ature (gage!						

			For State Registrar	State of	Marylan	d / Dep <i>Ce</i>	artment of Fertificate of	lealth and l Death		jiene	06	17177
			Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Hazel V. Wisman						May 14,		Toal	2315 P M
	Examin		4a. Facility Name (If not institution		nber)			r Location of Deatl	1	4c. County		
ı			Holy Cross Hosp				Silver Silver		1.0	Montg		
	Funeral Director		5. Social Security Number 228–44–1481	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 8		Months Days	Hours Min.	8. Date of Birth (Month, Day May 5,	1918	Virg	lace (State or Foreign try) inia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or l	ocation				1	0d. Inside City Limits
	deeth with the Maryland rme 23e or 28e-f ehow rmat be notified at	ō		mo r v		ver S						1 ☐ Yes 2X No
	28a-	Director	Maryland Montgo	mer y	311	VEL D	10f. Zip Code		1	log. Citizen of	What Coun	itry?
	3a or		3122 Gracefield	Road #402	2		20904			USA		
	deeth	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13	. Was Decedent of H	tispanic Origin? (S	pecify Yes or No- o Rican, etc.)		e - Americ	
20	d within 72 hours after deeth with the Marylar piene. r then "netural", or iteme 23e or 28a-f ehow the Madical Examiner must be mylliled at	by Fu	1 Never Married 2 Marri 3 Widowed 4 Divorced	ied 1 □Yes If Yes, Give	2 X No e		1 ☐ Yes 2 ☐XNo	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specif		
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7	e filed within al Hygiene. I other then '	ШO	Elementary/Secondary (0-12)	Coflege (1-	-40r 3+)	Homer	naker			Own Hor	ne	
ğ	be filed htal Hygi ed other event,	ВеС	17. Father's Name (First, Middle,	Last)					ne (First, Middle,		ne)	
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Jar	2 shd and ie m	- 73	19a. Informant's Name/Relations			1	ling Address (Street					
e)	l and 1ealth 1m 27 1her tu		James R. Wisman	/ son_	20h F	the second second second second	Veazey S			20c. Location		
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Baltimore,	if. Perinter intention of inch.		4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service		Che	sapeal	ce Cremato	ory 05/1	.7/06 E	eltsvil		
n	permit. Peges 1 and 2 should be Department of Health and Menta important: if item 27 ie marked any injury or other traumatic e once.		Bevery	LHele	# MO12	51 Be	Name and Addressing Home everly L.	Crematic Heckrott	on Servic ce, P.A.	e P.O. Clarks	Box	784 MD 21029
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	Physician		Immediate Cause (Final disease or condition	. Ventr	icular	Tachy	cardia					Onset and Death
	/Medical Examiner		resulting in death)		or as a consec					·		
	±Xummer	er	Sequentially list conditions in any, leading to immediate	b. Corona	ary Art		isease					
	nsit	nine	cause. Enter Underlying Cause (Disease or injury		or us a consoc	udi100 01).						
,	be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):						
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0	at the death certifi by the ettending I teched for use as	Physician/M	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4∐Pregna 9☐ Unkno	ant at time of c	leath 5	Other (specify) _					
<u> </u>	that I		Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use cont	tribute to th	e cause of death?
Records,	law requires that as been signed b 2 should be dete	d by							1 🗆 Y	es 2⊠No	3 ☐ Prob	ably 4 Unknown
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H	o ~ %	E							autops perfor 1 ☐ Yes	med?	prior to cor death? 1 □ Yes	npletion of cause of
Vital	iclan: Th certificete rector, pag	Bec	25. Was case referred to medical					26. Place of Dea	ath Check only or	Α		
	G 18	To E	examiner? 1 ☐ Yes 2 № No	Hospital: 1 □ Ir	npatient 2	ER/Outpation	ent 3 DOA	ner: 4 Nursing H	fome 5 ☐ Resid	ence 6 Oth	er (Specify	1)
Division of	ding Ph h. After th funeral		27. Manner of Death 1	9	of Injury h, Day Year)	28b. Time Injury	Wo		28d. Describe h	ow injury occur	red	
<u>S</u>	tend death tor: the	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	of fairne . At h			Yes 2 □No	20f Location /S	troat and Numb	or or Gue	l Route Number,
<u> </u>	or Attendent efter deatl Director:	Certification;	4 ☐ Homicide determ	ined 200. Flace	ng, etc. (Speci	fy)	treet, factory, office		City or Tow		er or Hura	i Addie Number,
	To the Hospital or Al within 24 hours efter of To the Funeral Direc completely filled in by		29a. Certifier Certifyin	g Physician: To the	best of my kno	wiedge, dea	ath occurred at the ti	me, date and place	a, and due to the c	ause(s) and m	anner as st	aled.
	n 24 h n 24 h he Fu pletely	edicai	(Check only 2 Medical one)	Examiner: On the ba	asis of examina ner stated.	ation and/or	nvestigation, in my	opinion, death occu	irred at the time, o	late and place,	and due to	the cause(s)
	To the H within 24 To the F complete	Σ	29b. Signature and title of certific	11 2+	-	M. 17	29c. Licen:	se number	2	9d. Date signe	d (Month,	Day, Year)
				den U	Osly	MI	D2364	9		May 15	200	6
(a2		30. Name and address of person	71 (1)					1m 0000			
<i>」</i>	- C4	10	John Stuckey, M. 31. Date filed (Month, Day, Year)		Gracefi Bistrar's Signi		d. Silver	Spring,	ми 20904			
	Sta Registi		MAY 1		leve		South ,					
							300					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Everette C. Warlick May 2006 11:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health of Denton Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□,M 2□ F Yrs 213-07-6734 90 **Director** June 15, 1915 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other then "natural", or Heme 23a or 28e-f show other traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Colonial Drive 21629 United States of America 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No 1941 -If Yes, Give Year or Dates: 10/5 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene important: if item 27 ie marked other then "na ong." Elementary/Secondary (0-12) Coflege (1-4or 5+) Steel worker Steel Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McClure Warlick Esther (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Warlick 410 Colonial Drive, Denton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Capital Crematory 5/22/2006 Dover, Delaware 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Moore Funeral Home, P.A. audoble 100mg 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** aspiration Dreuman /Medical Due to (or as a consequence of): Examiner Viegec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and thed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000 After this certificate has 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred of or Attending Patter death.

Director: After t Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospitei c hin 24 hours af the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Q M 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston Butter 21655 136 Lednum Melinde 31. Date filed (Month, Day, Year) WAY 2 2 2006 32. Registrar's Signature Registrar

			For State Registrar	State of Maryla	_	rtment of I			Reg. No.	006	17179
	Physici		1. Decedent's Name (First, Middle, Las MARJORY MAY	YOUNG				2. Date of De Month May	nath 12,	2 ^Y 006	3. Time of Death 9:55 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Dea	th		ounty of Death	
-			Casey House 5. Social Security Number 6. S	ev 7 Age (In vr	s. last birthday)	Rockv:		8. Date of Bir		ntgome	
	Funeral Director			□M 20XF 8	**	Months Days			ay, Year)	Ohio	place (State or Foreign htry) O
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation				1	10d. Inside City Limits
	Maryl -1 sho	tor	Md. Montgome	ery Ga	aithersl	ourg					1 X Yes 2 ☐ No
	or 28e	lrec	10e. Street and Number		·	10f. Zip Code			10g. Citizer	of What Cour	ntry?
	ath wit	ralD	407 Russell Ave.	#306		20				d State	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-f show aumatic event, the Modical Examinar mast be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:)	Vas Decedent of f Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, pecify: Whit	etc.
ည	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra		16a. Deced (Give	lent's Usual Occu kind of work done	pation during most of wo	orking		of Business/In	
21215-0036	within ene. then'	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			Administ			ral Eme gement	
Ö		0	17. Father's Name (First, Middle, Last)			-		me (First, Middle	, Maiden Su	тате)	
Maryland	should be find Mental His marked of	70 1	William F. Murphy					Fern Hine			
Mar	12 sho h and 7 ls m traum	11	19a. Informant's Name/Relationship (James Young (Nepl				tand Number or R D Plaza				Code)
<u>ရ</u>	Healt tem 2 other		20a. Method of Disposition		_	sition (Name of natory or other pla		Dallas, 15,		tion - City or To	own, State
Ē	Pages and of the state of the s		1 Burial 2 XCremation 3 4 Donation 5 Other (Specific	Removal Irom State		itan Cre	1 3		A1exa	andria,	Va.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked say Injury or other traumatic av once.		21. Signature of Funeral Service Licer	. Doey		Name and Addr East De	D	eVol Fun			Md. 20877
	Physicien pe executed by Medical Examiner physicien and physicien and physicien street physicien	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the decone cause on each line. a. Small Lym Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	phocytic equence of):		_	ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	death certif e attending od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	ital death 3	Ectopic pregnand Other (specify)	sy		230	I. Date of delive	ery Day Year
	julres tha n signed ald be de	۵	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause g	ven in Part I.				he cause of death?
Division of Vital Records,	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detach	Completed						24a. Was auto perfo 1 □ Yes	ormed?	death?	opsy findings available mpletion of cause of
<u> </u>	sicien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only		2011	Hospica
ion of	or Mite	atlon: To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation			28c. Inju		28d. Describe			y) Hospice
Divis	al or Atte	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f	Medical C	29a. Certifier 1 \(\overline{\text{X}}\) Certifying Pt (Check only one)	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	n occurred at the t restigation, in my	ime, date and plac opinion, death occ	e, and due to the surred at the time,	cause(s) an date and pla	d manner as si ace, and due to	lated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A			se number			igned (Month,	•
) ,			1 / / / / /	~ m	10	D35	5635		May	15, 200)6
1	9		30. Name and address f person A Dr. Joseph Kaplar			_{Print)} er Mill	Rd. Ro	ckville,	Md.	20850	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 16 2	32 Registrar's Sig	nature	ente					

Amend item#10e,20b,perfH,6856,61706 IT State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 6 **Physician** 5,02 MA STON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NURSING+ REHAB BALTIMORE ROCK GIEN BALTIMORE MD If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1⊠M 2□F MD P13.20.0329 10.31.191 Director Usual Residence of Deceden 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County Show r than "natural", or Items 23a or 28a-f shov the Medical Exercines must be notified at 1 ☐ Yes 2 X No Director GEORGES PRINCE mo BOWIE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20716 USA 2315 Alstead Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LEVER BROTHERS PLANT SUPERVISOR 12 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) permit, Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If item 27 is marked other any Injury or other traumatic evant. 17. Father's Name (First, Middle, Last) MAX ALSTON, SR. DESTER CROCKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 2315 ALSTEAD LN. BOWIE LILA M. NICHOLAS SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 06-04-2006 1 🖔 Burial 2 ☐ Cremation 3 ☐ Removal from State 05 BALTIMORE, MD ¹ 4 □ Donation 5 □ Other (Specify) ARBUTUS 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BAUD. NATU PIKE, BAUD. MO 21229 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Friysician ADVANCED unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No RECURRENT 1 ☐ Yes 2 🗷 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Dayle signed (Month, Day, Year) 29b. Signature and title of certifier D18362 24 06 Kerany amal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkers Ave. Suite LLIO. M.D. 3455 ROMALK DANG 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

sicia	n	Decedent's Name (First, Middle, L Calema	ast) Abdow	,				2. Date of D Month May		2006 Year	3. Time of Death 08:55a
edic		4a. Facility Name (If not institution, g			41	City Town o	r Location of Dea			. County of Death	
mine	er	Summerville P					omac			Montgom	
ral		Social Security Number 6.				Under 1 Year onths Days	If Under 24 Hrs				nplace (State or Fore untry)
tor		200-14-1035 Usual Residence of Decedent	1□ M 2√2 F	35 8	3 Yrs. "	Ontris Days	Tiours	11/08			nsylvani
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	ctor	MD MOntgo	mery		Kensing	ton					1 □ Yes 2 🔯 I
	Funeral Director	10e. Street and Number	D		1	10f. Zip Code	005		10g. Cit	tizen of What Co	untry?
Š	era	800 Hillridge	12. Was Decedent E	ver in U	S 13 Was		895	Specify Yes or N	0-	USA 14. Race - Amer	ncan Indian
Ĭ	Fun	1 Never Married 2 Married	Armed Forces?				lispanic Origin? (S an, Mexican, Puei	nto Rican, etc.)		Black, White	e, etc.
	ρ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	Yes 2X No	Specify:			Specify:	White
	Completed	15. Decedent's (Specify only highest g	Education trade completed)		16a. Decedent (Give kind	's Usual Occup of work done	pation during most of wo d)	orking	16b. K	ind of Business/I	ndustry
1	dω	Elementary/Secondary (0-12)	College (1-4or 5	+)		maker	a))tan Hom	
	ပိ	17. Father's Name (First, Middle, Las	st)		HOME	marer	18. Mother's Na	me (First, Middle		Own Hom Sumame)	ie
	To Be	Michael Davis					Nase	ma Dau	b		
		19a. Informant's Name/Relationship					and Number or R		ber, City o	or Town, State, Z	ip Code)
		Frank Abdow/S	on	1			Farm L		T		,Va 220
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State		Place of Disposition Temetery, cremator			Date	20c. Lo	ocation - City or 1	Town, State
		4 □Donation 5 □ Other (Spec		G	ate of						oring,Md
ouce.		21. Signatule of Funeral Service Lic			PHT 924		RÍNALD	I FUNE	RAL	SERVIC	E,P.A. g,Md209
	\dashv	23a. Part1. Enter the disease, or co shock, or heaft failure. List on	mplications that caused	the deat						. Spiii	Approximate Interval Between
١		Immediate Cause (Final disease or condition			osis						Onset and Death
ı		resulting in death)	Due to (or as								1 day
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	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as								
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ĺ	calE				nson's	diseas	se				years
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	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			topic pregnanc	u			23d. Date of deli-	
	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			her (specify)		· · · · · · · · · · · · · · · · · · ·		Month	Day Year
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	Completed					· · · · · · · · · · · · · · · · · · ·		auto	opsy formed?	prior to c death?	completion of cause
	Ö	25. Was case referred to medical					26 Place of De	1 ☐ Yes eath (Check only		1 Yes	2 No
	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatient :	3 DOA Ott				6 Nother (Spec	wassiste
	T.T	27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Inju		28d. Describe			living
	catic	2 Accident investigat	ion				Yes 2 □ No				
	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At h	ome, farm, street, y)	factory, office			(Street and own, State		ral Route Number,
		29a. Certifier 1 Certifying	Physician: To the best of	of my kno	owledge, death oc	curred at the t	me, date and plac	e, and due to the	e cause(s) and manner as	stated.
	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	examina	tion and/or invest	tigation, in my o	opinion, death occ	urred at the time	, date and	d place, and due	to the cause(s)
	Ň	29b. Signature and title of certifier	A 4.71	1. (225	29c. Licens		20	29d. Da	te signed (Month	
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			For State Registrar	State of M	laryland /		artment of H		ind Me		giene (36	17182
	Physici		1. Decedent's Name (First, Middle,	À	nana) <				2. Date of De.	Day L	200/a	3. Time of Death
V 10	/Medic		4a. Facility Name (If not institution,			()	4b. City, Town, or	Location of	f Death	1.107	4c. Count	of Death	1.01
	Examin	ier	Howard Co	inty Ger	ocal		Columbia				Howa	rd	
	Funeral			6. Sex 7. A	ge (in yrs. last b	irthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Bird (Month, Da	th		ace (State or Foreign
	Director		216-34-5815	1□M 2 X F	96	Yrs.	World's Day's	Tiodis		10/17			nuania
	pu &	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10	d. Inside City Limits
	Aaryle r eho	ō		ā	Woods								1 ☐ Yes 2 X No
	death with the Maryland rms 23a or 28a-f show	rect	Maryland Howard	<u> </u>	WOOGS	COCK	10f. Zip Code				10g. Citizen of	What Count	ry?
	23a or	٥		aust.			21163						
	ter death	era	10710 Croydon C	12. Was Deceden	t Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cubar	spanic Orig	gin? (Spec	ofy Yes or No	United 14. Rac	ce - America	in Indian,
	or ite	Ē	1 Never Married 2 Marrie	Armed Forces 1 Yes 2	No		ir Yes, specify Cubai 1 □ Yes 2 X No	n, Mexican, Specify:	, Puerto H	(ican, etc.)		ick, White, e	tc.
5-0036	72 hours after naturel', or ite	Completed by Funeral Director	3 □ Widowed 4 X Divorced	Year or Dates	:		10 163 2 140	эреспу.			Specil	Whit	
5-("natu	ete	15. Decedent' (Specify only highest		16	a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ition uring most	of workin	g	16b. Kind of B	Business/Ind	ustry
2121	within ene. then	ш	Elementary/Secondary (0-12)	College (1-4o				,			T ota		
	Hygie ther ther		17. Father's Name (First, Middle, L	5+ast)	A	ttor	ney	18. Mother	r's Name	(First, Middle,	Law Maiden Sumar	ne)	
an	id be ental ked c	To Be	Zigmas Treideri	s				Mago	delen	a Bara	ukas		
Maryland	s I and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene Item 27 Is marked other than "naturel", or Items 23s or 28s-1 ehov Item 27 Is marked other than "naturel", or Items 23s or 28s-1 ehov Item Wadical Examination ovent. Ite Madical Examination ust be natilised at		19a. Informant's Name/Relationsh		19	b. Mailir	ng Address (Street a					, State, Zip	Code)
	and 2 salth ar		Donna Armanas -	Daughter-I	n-Law	1071	0 Croydon	Cour	ct Wo	odstoc	k, Mary	land 2	21163
ore	0 O		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	-	20b. Place	of Dispo	sition (Name of matory or other place		Da	ate	20c. Location	- City or Tov	vn, State
Ē	Page: ment of ent: If ury or		4 □ Donation 5 □ Other (Sp			on F	Park Cemet	ery	06/02	/2006	Baltim	ore, N	Maryland
Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service L	icensee			2. Name and Addres			mal Ho	mag D A		
_	70 E 9 9		Warnet ,	1. Oh Men		Ē	311 Edmor	dson	Aven	ue Bal	timore,	•Mary	land 21229
			23a. Part1. Enter the disease or shock, or heart failure. List of	complications that cause only one cause on each	line.	o not ent	er the mode of dying	, such as	cardiac or	respiratory a	rrest,	4.7	Approximate nterval Between Onset and Death
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	* 8 .	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence	e of):	M	W(,	X			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		350	2	wifels	21	04	4			
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39 ×	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE:										
Вох	ath cuttend	lan/	23b. Was decedent pregnant in the past № fronths?		e or pregnancy 2 ☐ Fetal dea at time of death		Ectopic pregnancy					ate of deliver onth	y Day Year
0	at the de by the a tached f	ysic	1 ☐ Yes 2 DNo 9 ☐ Unknown	9☐ Unknown	at time of death	5[Other (specify)						
<u>α</u>	that t ed by deta		Part II. Other significant condition	ns contributing to death	but not resulting	in the u	nderlying cause give	n in Part I.		23e. Did t	obacco use cop	thibute to the	e cause of death?
Records,	w requires that been signed to should be deta	d by								1 🗆 '	Yes 2	3 🗌 Proba	ably 4 Unknown
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2	ding Ph h. After th funeral		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of In (Month, L	jury Jay Year) 28b	. Time o Injury	Work			8d. Describe I	how injury occur	rred	
sio	Attending Physician: r death. sctor: After this certilic by the funeral director.	cati	2 Accident investig	-4		4		res 2 🗆 l		Of Leasting /	Street and Num	han a - 7 1	O- d- M
Division of	or At after of Direction by	Certification;	4 Homicide determi	ned 288. Place of the building,	etc. (Specify)	rarm, sti	reet, factory, office		4	City or To		oer or Hurai	Houle Number,
	Hospitel 14 hours a Funeral I	Ö	29a. Certifier 1 Certifying	Physician: To the bes	st of my knowled	ge, deat	h occurred at the tim	ie, date and	d place, a	nd due to the	cause(s) and m	anner as sta	ated.
	To the Hospitel or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical tone)	xaminer: On the basis and manner	of examination a	and/or in	vestigation, in my op	oinion, deat	th occurre	d at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certaier	ALA	las.		29c. License	number	15	79	29d. Date signe	ed (Month, E	Day, Year)
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			1 - For Stata Registrar	State of Ma	ırylan		artmen			and M		Reg. No.	.000	A Commission in the Commission	83
ls.	Physici	an	Decedent's Name (First, Middle, Las HARRIE*	*			AZRAE	1			2. Date of D	26, Day	2006 Year	3. Time of 2:00	f Death A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	#309			Town, or	Location o				County of Dea		
	Funeral Director		5. Social Security Number 452-03-7805 1 Usual Residence of Decedent	ex 7. Age □ M 2	93 (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	**************************************	9. Bi	rthplace (State ountry) MD	or Foreign
	Maryland I-f show	tor	10a. State 10b. County MD N/A		10c. Cit	y, Town or Lo								10d. Inside C 1 X Yes	ity Limits 2 🗌 No
	vith the	Director	10e. Street and Number	- AVENUE #1	200		10f. Zip		21215			10g. Citi	zen of What C	ountry? USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show enty injury or other traumatic event, the Mudical Extractional the notified at ance.	1 by Funerai	7121 PARK HEIGHTS 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ver in U		Was Deced If Yes, spec	lent of H			ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	erican Indian,	
Maryland 21215-0036	d within 72 hagiene.	Completed	15. Decedent's Ec (Specify only highest gra	ducation de completed) College (1-4or 5	+)	16a. Dece (Give life. HOMEM	dent's Usua kind of woi DO NOT us AKER	al Occupa rk done d se retired	ation during mos	t of worki	ng		HOME	s/Industry	
yland	ould be file Mental Hy arked other atic event,	To Be (17. Father's Name (First, Middle, Last) HENRY			GLASS			RE	BECC				MILL	.EN
Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (1										r Town, State,		
Baltimore,	Pages 1 ar nent of Hea ant: if item : ury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of the control	Removal from State	0	Place of Disponentery, cred	matory`or o	ther plac			3/2006		cation - City o		
Balti	permit. Departm Imports eny inju		21. Signature of Funeral Service Licer	Leviso	n	2;	2. Name an			•				ROS., IN	
760,	Physician /Medical Examiner pe prize pe	icai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or a) Due to (or	a conseq	uence of):	-	e of dyin		cardiac	or respiratory	arrest,		Approximatinterval Bei	tween
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Il death 3	Ectopic pr		,				23d. Date of de Month		Year
	quires that t n signed by uld be deta	à	Part II. Other significant conditions of	ontributing to death bu	ut not res	sulting in the u	inderlying c	ause givi	en in Part I				_	to the cause of o	
Vital Records,	The law require ate has been si page 2 should b	Completed											prior to death?		available ause of
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Isna .		Dth	er		Check only		2 1700		
ion of	Jing After	ation: To	1 Yes 12 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui	rv	28b. Time o Injury		28c. Injun Wor	4 🗆 140		28d. Describe		6 □Other (Sp y occurred	өспу)	
Division	el or Attend s after deatl al Director: ed in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injubuilding, etc	ury - At h	ome, farm, st	reet, factory	y, office				(Street an own, State		Rural Route Nun	nber.
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	(Check only 2 Medical Exar	nysician: To the best on the basis of and manner sta	examina	owledge, deal ation and/or in	ivestigation	, in my o	pinion, dea	nd place, ith occurr	and due to the ed at the time	, date and	f place, and du	e to the cause(s)
)	To To com	₹	29b. Signature and title of certifier	40		00-1) (T		Di	809 e unmper	1		29d. Dai	te signed (Mor	Ody, Year)	
Ì	0		30. Name and address of person who	MERY	ear (Iter	W	USP V	CA	108	2					1
200	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 1	2006 32. Redistra	ar's Signa	ature	peak	,							

Division of Vital Records, P.O. Box 68760.

		1 - For State Registrar	Oldio of Maryla		tificate of l			Reg. No.	0 1/104
Physic		Decedent's Name (First, Middle, Late MORRIS	st)		ALPERT		2. Date of Dea		3. Time of Death 8:40 A M
/Medi Exami		4a. Facility Name (If not institution, giv. RUXTON PIKESVIL		ME	4b. City, Town, or PIKESV	Location of Death		4c. County of I	
Funeral Director		214-20-3433	C	s. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Da 06/27/	9. 1926	Birthplace (State or Foreign Country) MD
th with the Maryland 23a or 28a-f ehow	ctor		/A	City, Town or Lo		BALTIMOR			10d. Inside City Limits 1 Yes 2 No
h with th	al Dire	10e. Street and Number 3011 FALLSTAFF R	OAD #301-A		10f. Zip Code	21209		10g. Citizen of Wha	it Country? USA
e filed within 72 hours after death with the Maryland at Hygiene. other than "neturel", or iteme 23a or 28a-f ehow vent, the Moucal Expulprer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 🐧 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🏋 No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc. WHITE
within 72 ho iene. r than "netur the way call	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired MAN	during most of wor	king	16b. Kind of Busin	
s 1 and 2 should be filed within if Health and Mental Hygiene. Hem 27 is marked other than other traumatic event, the M.	Be	17. Father's Name (First, Middle, Last, BENJAMIN		ALPER'	т П	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	KING
2 should be for and Mental His marked of raumatic eve	5	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru		ər, City or Town, Sta	
es 1 and 2 of Health a of Item 27 is		ELAINE ALPERT / 20a. Method of Disposition		. Place of Dispo	FALLSTAF sition (Name of		301-A	BALTIMORI 20c. Location - Cit	E, MD 21209
Pages nent of ant: If It ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State y) MO	-	natory or other place TEFIORE C		1/2006		HORPE, MD
permit. Pages Department of h Important: If Ite eny injury or or once.		21. Signature of Funeral Service Lice	Getten					SON & BROS	S., INC. E, MD 21208
Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	plications that caused the de one cause on each line. a. Due to (or as a consider.) Due to (or as a consider.)	equence of):		g, such as cardiac			Approximate Interval Between Onset and Peath
rificate be executed ng physicien and as the burial-transit	Medical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a const	equence of):					
at the death certificate by the attending physi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy			23d. Date o Month	•
Attending Physician: The law requires that the death ce or death. In death. ector: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	b	Part II. Other significant conditions of	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.			ite to the cause of death? ☐ Probably 4 ☐Unknown
reician: The law r s certificate has be lirector, page 2 sh	Completed		per fension	,			1 ☐ Yes	osy rmed2 dea 2 No 1 □	re autopsy findings available r to completion of cause of th? Yes 2 No
nysiciar nis certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	05	ome 5 ☐ Resid	<i>ne)</i> dence 6 □Other((Specify)
ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	now injury occurred	-
To the Hospital or Attendi within 24 hours after dearh. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 4 Homicide 6 Could not be determined	e 290 Place of Injury At	t home, farm, str cify)	eet, factory, office		28f. Location (S City or Tov		or Rural Route Number,
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in I	edicai		nysician: To the best of my k niner: On the basis of exami and manner stated.						
To the within To the compl	Me	29b. Signature and tipe of continer	11)		29c. Licens	e number 7 5 6 5		29d. Date signed (A	Month, Day, Year)
5T		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print)	38 G	eeno	Tree	106 Rd 21208
Si	tate	31. Date filed (Month, Day, Year)	32. Régistrar's Sig	pnature	Coast)		~~~		2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 2:50 **Physician** 2001 (eqory William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) 10 Jenera If Under 1 Year 8. Date of Birth 9. Birthplace (Sta (Month, Day, Year)

December 4, 1957 Maryland Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 212-58-177. Days Hours 1/8M 2 F Months Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?? Ie marked other than "natural", or Iteme 23a or 28a-f ehow treumatic event, the Medical Examinar must be notified at BAHIMORE 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code CESA Ave 2121 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 124 DISabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H William FRANKLIA trances. 8. Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any Injury or other treu 2556 Druid Heie Ace. Brown - Spouse BAltimore Md 21217 1-mgela 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State netru Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Jonat e of Funeral Service Licensee MANCE M. WALLACE FUNEARE SERVICED
3405 W. FRANKLINGST-BAILMORE MIL & Md 21229 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearthailure. List only one cause on each fine. Approximate Interval Between Onset and Death ENCEPHELOPATHS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) CIR RHOSIC Examiner DVBNCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physiclen and for use es the burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown م Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by CITESISEVERE 1 Yes 2 XNo 3 Probably 4 Unknown HEPATOREMAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 21 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death fnjury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00

State Registrar

31. Date filed (Month, Day, Year)

BJAIR

32. Registrar's Signature

DHU mis

N 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State	of Maryla		rtment of I		nd Mental H	ygiene Reg. No	F 000	17186
	6		Decedent's Name (First, Middle, L.	ast)					2. Date of I			3. Time of Death
	Physicia /Medic		Mary Linnea 1	Bavis					May	27		1:15 A M
	Examin		4a. Facility Name (If not institution, gi	ve street and no	um ber)		4b. City, Town,		Death	40	. County of Deat	
			Stella Maris		7 4 //	In a blade day.	Timo:		4 Hrs. 8. Date of E	Timb	Balti	
	Funeral Director		5. Social Security Number 6. 212-88-9653	Sex 1 □ M 2 🛛 F	7. Age (In yrs	s. last birthday) Yrs.	Months Days	Hours	Min. Jan.	Day Year	959 Mari	nplace (State or Foreign untry) ILAND
			Usual Residence of Decedent						3000	, , , ,	, , , , , , , , ,	
	nylan show		10a. State 10b. County		10c. C	City, Town or Lo						10d. Inside City Limits
	Ba-f	ecto	Maryland Baltin	nore		P	noenix	·		10: 0	tizen of What Co	1 ☐ Yes 2V No
	a or 2		10e. Street and Number 3605 D Southside	Avenue	,		10f. Zip Code	21131		10g. CI	U.S.A.	untry ?
	death with the Maryland ime 23a or 28a-f ehow	Funeral Director	11. Marital Status	12. Was De	cedent Ever in	U.S. 13. \	Vas Decedent of I		in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ame	
0	or iter	Fur	1 X Never Married 2 ☐ Married	Armed F 1 Yes If Yes, G	2 X No		fYes, specify Cub I□Yes 2 X No		Puerto Rican, etc.)		Black, White	o, otc. hite
	be filed within 72 hours after death with the Marylan nia Hygiene. ad other than "natural; or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or	Dates:							
5	"natu	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Deced	lent's Usual Occu kind of work done DO NOT use retire	pation during most (d)	of working	16b. K	(ind of Business/	Industry
7	withir	ошо	Elementary/Secondary (0-12)	College	(1-4or 5+)		r Worked				N/A	
5	other,	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother	s Name (First, Midd	lle, Maider	Sumame)	
/iand	2 should be and Mental ie marked o eumatic eve	To B	Robert Joseph	Bavis,	Jr.			М.	Phyllis	Schu	tte	
lan.	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship			400			or Rural Route Nun			
e,	1 and Health em 27 ther t		Mrs. Patricia Pi 20a. Method of Disposition	uler (s					ve., Phoei		MD 2113 ocation - City or	
Ď	Pages nent of l int: if its iry or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1 State		sition (Name of natory or other pla n P P out Mon		5/30/2006			
			21. Signature of Funeral Service Lic		Pu				Schimunel			
ñ	permit. Departr imports any inje		1/1/1/1	//					, Baltimo			103
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that y one cause on	caused the des	ath. Do not ent	er the mode of dy	ng, such aş c	ardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 21	D Sto	age i	deme	ntla				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):						
		-	Sequentially list conditions,	b. — Due to	(Ur as a cunse	equence of).						
	uted J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		`							
ĵ	be executed ician and burial-transit		resulting in death) Last	Due to	o (or as a conse	equence of):						
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٥	ertific ding p	0	IF FEMALE:	23c Huge o	utcome of preg	nanov						
Š	death certificate e attending phys d for use as the	ician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 ∐ Fe anant at time of	tal death 3	Ectopic pregnance Other (specify) _	У			23d. Date of del Month	very Day Year
j.	y th	hysic	1 ☐ Yes 2 MaNo 9 ☐ Unknown	9□ Unk			, c (open,)) _					
λ, J	requires that een signed b hould be deta	by Pl	Part II. Other significant conditions	contributing to	death but not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
ğ	equire en sig puld b					_ -			1[]Yes 2	□No 3□Pr	obabiy 4 Unknown
ecord	8 S S	Completed							24a. W	topsy	prior to o	topsy findings available completion of cause of
<u> </u>		Con							pe 1 ☐ Yes	rformed? 2 No	death? 1 ☐ Yes	2[] No
VITa	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	: 2500 (- M)		Ot		of Death (Check on)			
ō	Phys r this ral di	.: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatier 28b. Time o	I 3 DOA	4 ZNNurs	sing Home 5 Re			cify)
0	nding th. r: Afte e fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		nth, Day Year)	Injury		ork?]Yes 2∐N	0			
DIVISION	or Attending Physician: ifer death. Director: After this certific in by the funeral director.	Certification;	3 Suicide 6 Could not	289. Plac	ce of Injury - At	home, farm, str	eet, factory, office		28f. Location City or	(Street a	nd Number or Ru	ral Route Number,
5	itat or irs afte rai Di											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier t Certifying (Check only one)	aminer: On the	ne best of my ki basis of examin nner stated.	nowledge, deat nation and/or in	n occurred at the t vestigation, in my	ime, date and opinion, death	place, and due to the control occurred at the time	ne cause(s e, date an) and manner as d place, and due	stated. to the cause(s)
	o the	Med	29b. Signature and title of certifier		312100		29c. Licen	se number		29d. Da	ite signed (Monti	n, Day, Year)
}	~ > = 0		1				1	1372	-5	Ma	429.	2006
	10		30. Name and address of person wh	o completed car	use of death (It	em 23a) (Type,	Print)		17 11	00	+ 1	
	Ч		pr laria 1	Ylahw	100d	L30	O DUI	aney	Valley	Ka	11 mon	ium, Md
	Sta Registr		31. Date filed (Month, Day, Kear)	006	Begistrar's Sig	uatora	-	-				21040
				UUU #1	27 . 0	DET	- 407 -					

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Amend #17&20b Per FH C856, 6/07/06 III

For Amend Items 25,27,28a f per ME, 6855,05/30/06dhb

Registra Amend Item 1 per Dr., 6856,06/06/06dhb of Death

Registra Amend Item 1 per Dr., 6856,06/06/06dhb of Death

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Registra Amend Item 1 per Dr., 6856,06/06/06dhb of Death

Registra Amend Item 1 per Dr., 6856,06/06/06dhb of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Carl Frederick 3. Time of Death Brensinger Month Day Year **Physician** Carl Frederick 4:55 P 21, 2006 Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **₩**₩ 2□ F 83 Yrs. 577 22 2820 Jan 16, 1923 Virginia Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow treumatic event, the Mudical Examiner must be notified at 1 Yes XX No Clinton Maryland Prince George's ē 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 20735 12307 Windbrooke Drive United States 238 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 10. 192 14. 193 2 □ No 16 Yes. Give 1 0.0 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1943 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🖁 No Specify. Specify: White 1945 ģ 3 ☐ Widowed 4 ☐ Divorced "naturei", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 7 th College (1-4or 5+) Painter Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental H is marked of Arthur Bresinger Brensinger Lola B. Simmons ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12307 Windbrooke Drive, Clinton, MD 20735 Juanita Eade (care Giver) item 27 i May 01,2006 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages ment of that cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. Cheltenham, Maryland Maryland Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 663301d Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fat Embolism **Physician** 10 Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 11 Days Acute Hip Fracture, Traumatic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical CERTIFICATION IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t P.O. 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š Chronic Obstructive Pulmonary Disease Completed 1 X es 2 No 3 Probably 4 Unknown Right Ischemic Lower Extremity 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Peripheral Artery Disease certificate 1 Yes XX No 1 🗌 Yes 2 No Vital Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Valnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2 □ No ဥ After this funeral dir Division of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At correletaly filled in heart. Unknown M 1 ☐ Yes 2 XXNo Fall at home investigation 2X Accident At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number MD City of Town, State)
12307 Windbrooke dr., Clinton 4 Homicide determined at home 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 42049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14314 Old Marlboro Pike, Upper Marlboro, MD 20772 Alain G. Champaloux, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2006

John

Please Type or Print in Black Indelible Ink

Arthur Brei		1- For State Registrar		ate of Mary	rianu /		tificate of			vieritai		Re	eg. N o.	20	1) 6	5 1718
Physicia lical Exami		1. Decedent's Nam John Ar		rennan,	Jr.						N	ate of Dear Nonth ay 24, 2	Day	Year	1	3. Time of Death 1 1034 hrs
		4a. Facility Name (if not institution				4	b. City, To		cation of De	eath		4c.	county of I	Death	
Funeral Director		5. Social Security N	3695	6. Sex	_		ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours		Nov .			9 Birth oreign Cour	
Maryland 28a-f show any <u>d at once.</u>	ctor	Usual Residence o 10a. State MD 10e. Street and Nu	10b. County n/a	i			Town or Location		Code			I 10	Da Citize	en of What		1 XXYes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	al Director	632 Harv			lecedent l	Ever in U :	S 113 Was	21:	230	ole Orlain?	(Specifi		Jnit	ed St	ate	
	by Funeral	1 Never Marri 3 Widowed	4 Div		Forces? 2 2	X] No	If Ye	es, specify Yes 2	Cuban, M X N o s	exican, Pue	erto Rica	in, etc.)	s	White, e	wh.	ite
21215-0036 Ild be filed within 72 hours after vlental Hygiene narked other than "natural", event, the Medical Examiner	Completed	Elementary/Second 12 year	ondary (0-12)	College 4 ye	(1-4 or 5		House	ost of worki	ter			st, Middle, N	Anden S		int	ing
21215-0036 suld be filed within 7 Mental Hygiene marked other than c event, the Medica	To Be Co		A. Bren	nan, Sr.			19b. Mailing	Address		Jôan	Some	erby		,	State 2	Zip Code)
MD 2 show alth and 2 is in 27 is is aumatic	_	Beth Ste	etson (20h B	1	Broadn	neado	w St.		t.6 Ma	ar1b		MA	01752
Baltimore, MD 21215 permit Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, th		1 Burial 2 4 Donation 5	Cremation Other S		I from Sta	ate c	rematory or oth	ner place) remato	ory	5-	-30-2	2006	Ba:	ltimo	re,	
		21. Signature of Fu	7	J. Wayne	0st	erlin	Mc(ng 130	ully- DE.]	dgress of Poly Fort	niak Ave.	Fune Bal	eral I	Home e, Ml	P.A D 21	<u> 230</u>	
Physician /Medical Examiner		23a Part I. Enter the failure List on Immediate Cause or condition resulting	nly one cause (Final disease	A 4l	lerotic (Cardiova	ascular Dise		dying, suc	ch as cardia	ac or res	piratory arre	est, shoc	k, or heart		Approximate Interval Between Onset and Death
bd sit	Examiner	Sequentially list co if any, leading to in cause. Enter Undo (Disease or injury events resulting in	mmediate erlying Cause mat initiates	b. Due to (or a c Due to (or a									-			-
e executed reian and rial - transit		UNPENDED)	d. AMENDE	D											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	ysician/Medical	IF FEMALE: 23b. Was decedent past 12 months	s?	he 1 Liv	e birth	ne of pregr	2 Fet	tal death ner (Specif		Ectopic pre	gnancy			Date of de Month	livery Da	y Year
, P.O. Be rres that the de signed by the be detached f	d by Phy	Part II. Other sign	ificant condi	tions contribution	g to death	but not re	esulting in the u	nderlying c	ause give	n in Part I.		23e Did to				e cause of death?
Records, The law requir icate has been a page 2 should	Completed				-		-				_	24a Was autop perfor 1 ✓ Yes	sy med?	prio dea		psy findings available inpletion of cause of
f Vital Rec Physiciau: The r this certificate ral director, page	To Be	25 Was case reference examiner? 1 ✓ Yes 27. Manner of Dea	2 No	Hospital: 1	Inpatie		ER/Outpatient	3 DO			rsing Ho		Residen		Other:	
Sion of Attending Pl r death. ector: After by the funeral	ertification:	1 Natural 2 Accident	5 Pen	ding estigation	onth, Day,Y	ear)	ome, farm, stree		1 Yes	2 No					or Dura	Route Number, City
Divi lospital or l hours after uneral Dir	O	3 Suicide 4 Homicide 29a. Certifier	dete	Id not be ermined (Special Physician: To the	fy)		-					or Town, S	tate)			
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2	Medical Exa	aminer: On the bas and manne	is of exar			ion, in my o	pinion, de	eath occurre			and plac	e, and due	to the	cause(s)
	Σ	29b Signature and	d title of certification	bell	1				O.C.M.					ate signed 25, 2006		h, Day, Year)
3		Laron Lock	e MD. A	n who completed o	cal Exa	aminer	111 Penn	Street, I	Baltimo	re, MD 2	1201					
S Regis	tate		JON Year	1 2006 32.	Registra	r's Signatu	ire /	rede								

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of Ma	ryland		tment of Hi ificate of L			giene Reg. No.	06	17189
	Dii-i-		1. Decedent's Name (First, Middle, Las) ,		Ω.	20/00	1-0	2. Date of De Month		Year	3. Time of Death
	Physicia /Medic	al -	Stanley Hu	ston			4b. City, Town, or		Mary	Day 38 3	1006	1:47 PM
) —	Examin Funeral Director	-	5. Social Security Number 6. Se	Boyriew M	(In yrs. las	enter		If Under 24 H	rs. 8. Date of Bir	th y, Year)		ace (State or Foreign y) ucky
	ס		Usual Residence of Decedent				.:				10	d. Inside City Limits
	ehow	7	10a. State 10b. County			Town or Loca						1⊠Yes 2□No
	the M	Director	WV Grant 10e. Street and Number		rete	rsburg	10f. Zip Code			10g. Citizen of W	hat Count	ry?
	3a or		120 Lee Street				26847			USA		
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		1 11	as Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		- America , White, e	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, ite Modrel Examinar must be notilised at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1978 1982	3-	Yes 22No	Specify:		Specify:	Whi	te
5-0	natu	Completed by	15. Decedent's Ed (Specify only highest grades)	ucation de completed)		(Give k	int's Usual Occupa ind of work done of O NOT use retired	luring most of v	vorking	16b. Kind of Bus	siness/Ind	ustry
121	within ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		ctrician	,		Domina	ion P	ower
d 2	be filed tal Hygie of other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle	, Maiden Sumame	9)	
/lar	2 should be fited within and Mental Hygiene. ie marked other than aumatic event, the Mental Mental contractions.	To B	Glenn Branham						cia Mae N			
Man	2 should and resum		19a. Informant's Name/Relationship (7						Rural Route Numb			Code)
e,	ges t and 2 should t of Health and Mer If item 27 ie marke or other traumatic		Teresa Mae Branha 20a, Method of Disposition	m/Wife	20b. Pla	ce of Dispos	tion (Name of		ersburg,	20c. Location - 0		vn, Stete
mor	Pages nent of I int: If its iry or o		1 🖾 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Sout	th Bra	nch Vall Gardens	ey 6/	2/06	Petersbu	ırg,	WV
altii	permit. Pag Department Important: I any injury o		21. Signa ure of Funeral Service Liven		TICIN	22.	Name and Address	s of Facility	Schaeffer	r Funera	Hom	e, Inc.
8	89558		Dennis J.	Mman					reet, Pet		, WV	26847
	Physician	e a	23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	ne death.	Do not ente	r the mode of dyln	g, such as card	liac or respiratory a	irrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a	na	In	luny		1			2 months
	uted d ansit	Examiner	if any, leading to immediate cause. Enter or Joseph Cause (Disease or injury that initiated events	Due to (or as a	conseque	nce of):	nlury	. /\	AA	1		2 months
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	conseque	nce of):	3	71	//~	MINER		
9	ificate g phy: as the	ledic		. u			A)	/ /	BYME	DICAL		
O. Box	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 1	Fetal o	leath 3 🔲	Ectopic pregnancy Other (specify)	CENTHONY	ON APPROVED BY MEE	23d. Date Mor	of delive	y Day Year
s, P	The law requires that the date has been signed by the bage 2 should be detached	by	Part II. Other significant conditions of	ontributing to death bu	t not result	ing in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use contr	bute to th	·=
of Vital Record		Completed							24a. Was auto perfe 1 🗆 Yes	psy pormed? d	rior to con eath?	sy findings available apletion of cause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:	, ,,,,,,	D/O-t	o Doch	05	Death (Check only		e (Casala	
	Phys rr this aral dia	. To	1 No 2 No 27. Manner of Death	28a. Date of Injur	y 2	R/Outpatient 28b. Time of	28c. Injur	y at	g Home 5 Res 28d. Describe	how injury occurre	-)
ion	Attending Isr death. ector: After by the funer	atior	1 □ Natural 5 □ Pending 2 ★ Accident investigation	March Z	70ar)	UNK	M DE	Yes 2 □ No	Subject	t was-	elect	vocited
Division	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ry - At hon . <i>(Specify)</i>		et, factory, office		City or To	Street and Number wn, State) Ht. 5	ofocm.	Pare Station
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exer	niner: On the basis of and manner sta	f my know examination	ledge, death	occurred at the tir estigation, in my o	ne, date and pla pinion, death o	ace, and due to the	cause(s) and mai	nner as st	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		_		29c. Licens			29d. Date signed	(Month, I	
•	1		19 Ato	M.				- 00	0	May o	18,	2006
	10		Eric J. Hanly		00 1	Verth	Wolfe S		Baltimo	re, Mar	ylan	d 21287
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 1 20	32 Registra	s Signati	Son Son	Mes .				1	

			State of Maryland / Dep	partment of Health and Ment		ΕĤ
			1 - State Registrar Co	ertificate of Death	Reg. No.	U
Æ	Physici	an	1. Decedent's Name (First, Middle, Last)	» M	ate of Death 3. Time of Death lonth Day Year	
	/Medic	al	Virginia Lee Braun 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	44 23 2006 10:30P	
1	Examin	er	Future Care Of The Chesapeake	Arnold	Anne Arundel	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min (M	ate of Birth fonth, Day, Year) 9. Birthplace (State or Forei Country)	gn
*	Director		220-18-4166		/28/1926 MD	
	nytand how		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limi	
	8a-fs	ecto	MD Anne Arundel Pasado		1 Tyes 2 N	10
	within 72 hours after death with the Maryland ene. then "neturel", or (tema 23a or 28a-f show fe Modical Examilier must be notified at	Funeral Director	10e. Street and Number 1611 Colony Road	10f. Zip Code 21122	10g. Citizen of What Country? U.S.A.	
	death	nera		B. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican		
36	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Married II Yes Give	1 ☐ Yes 2 No Specify:	Specify: White	
Ö	hours sture!	ed b		edent's Usual Occupation	16b. Kind of Business/Industry	
215	hin 72 Bn na	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)		
21	led will lygien her th		12 Ho	omemaker	Own Home	
and	d be filed antal Hygie ted other c event, II	o Be	Horace Vineyard		h Fenzel	
ary	shoul and Me a mark	은		iling Address (Street and Number or Rural Rou		
Ž	and 2 salth a n 27 ls				len Burnie, MD 21061	
lore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or itema 23a or 28a-f show any injury or other traumatic event, if a Moolical Examination must be notified at ance.		A Burial 2 Cremation 3 Hemoval from State	position (Name of Date rematory or other place)	20c. Location · City or Town, State	
Baltimore, Maryland 21215-0036	artmen ortant injury	1		ridge Mem Pk 05/26	/06_Baltimore, MD once Funeral Home, PA	Δ
Ba	Depa Impo any ir		7 10		Pasadena, MD 21122	
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart lailure. List only one cause on each line.	inter the mode of dying, such as cardiac or resp	Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death) a. CEREBROVAS	CULAR DISEASE	Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):			
7°		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) Last — Due to (or as a consequence of):			
687	ficate p phys		d			_
Box	leath certifica attending pt d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	B Ectopic pregnancy	23d. Date of delivery Month Day Year	
Ö.	ne dea the at hed fo	/sici	in the past 12 months? 1 □ Yes 2 to No 9 □ Unknown 9 □ Unknown	Other (specify)	Month Day 16a1	
P.O.	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 2	23e. Did tobacco use contribute to the cause of death?	
Division of Vital Records,	w requires that been signed I should be det	Completed by	CORONARY ARTERY DISE	7 S E	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow	٧n
900	law re as bee 2 sho	plet	ATRIAL FIBRILLATION	2	24a. Was an autopsy lindings availab prior to completion of cause o	ole H
<u> </u>		Соп	COLITIS	1	performed? death? ☐ Yes 25 No 1 ☐ Yes 2 ☐ No	
Vit.	Physician: The law r this certificete has b ral director, page 2 s	o Be	25. Was case referred to medical examiner? 1	26. Place of Death (Che	ack only one) 5 ☐ Residence 6 ☐ Other (Specify)	
o	> 01 0	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. D	Describe how injury occurred	
sior	Attending r death. sctor: After	catio	2 Accident investigation	M 1 Yes 2 No		
Σį	or Attendate death I Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, building, etc. (Specify)		ocation (Street and Number or Rural Route Number, ity or Town, State)	
_	To the Hospital or Attending Phyminic 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, de			
	he Ho in 24 h he Fu ipletely	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or one) and manner stated.			
	To the I	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	^		30. Name and address of person who completed cause of death (Item 23a) (Typ.	e. Print)	1111 01, 2000	
	U		Mobil Nep 8601 Veterans Hu	vy Suite 204 Mil	MAY 24, 2006 Mersville, MD 21108	,
4	St. Regist	ate	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	house,		
2	negisi	rai	DON O I LOUD REMINES LO	ZAP-SA		

			1 - For State Registranend Item #2	State of Marylan						Reg. No	2000	171	91
	Physici /Medio	an	Decedent's Name (First, Middle, Last) JAMES	BEATTIE					2. Date of D Month MAY	Da	y Yeer	3. Time of D	M M
	Examir		4a. Facility Name (If not institution, give single 2400 WINCHESTER		РТ. F	,	, Town, or	Location of D			. County of Death	1	
	Funeral Director		5. Social Security Number 6. Sex 1 2 2 3 4 2 0 9 3 x			If Unde Months	r 1 Year	If Onder 24 I		irth Day, Year) 30,	9. Birth Cot 1931 SC		
	Aaryland Ped at	ō	Usual Residence of Decedent 10a. State 10b. County MD • N/A	10c. Cit	y, Town or Lo		E				CA	ROLINA 10d. Inside City Yas 2	y Limits
	or 28a-f	Direct	10e. Street and Number			10f. Zi	p Code		_	10g. Cit	tizen ol What Co	untry?	
36	t within 72 hours after deeth with the Maryland liene. r then "neturel", or Iteme 23e or 28e-f ehow the Medical Examinar must be notified at	by Funeral Director	2400 WINCHESTER 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:					? (Specify Yes or Nuerto Rican, etc.)		JSA 14. Race - Amer Black, White	e, etc.	
21215-0036	nin 72 hou n "nature Vedicel E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation	16a. Deced (Give life.	kind of w	ual Occupa ork done d use retired,	uring most of	working	16b. K	(ind of Business/I	ndustry	
	be filed ital Hyg od othe event,	Be	5TH 17. Father's Name (First, Middle, Last) GEORGE BEATTI		STE	EL_W	ORKE	18. Mother's	Name (First, Midd	le, Maiden		STEEL	⊢ C O.
Baltimore, Maryland	permit. Peges 1 end 2 should Department of Heelth and Mer Important: If Item 27 le marke any njury or other traumetic once.	То	19a. Informant's Name/Relationship (Type JANET CHEW STE 20a. Method of Disposition 1 Burial 1 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense	De, Print) DAUGHTER 200. F emoval from State	3109 Place of Dispo emetery, crer ZION	9 CA esition (Namatory or Cerro	MBRI ame of other place	DGE D Ju s of Facility	RIVE, W Date ne GGS FUN	INDS 20c. L	Or Town, State, 2 SOR MIL ocation - City or	L MD 2 Town, State	1244
8760,	death certificate be executed Wedgical e attending physicien and dor use as the buriat-transit	lical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	uence of): uence of): uence of):	ter the mo	E. P. de ol dying	g, such as car	N ST. B. diac or respiratory	arrest,	DISLOWSIE	1 21 3 Approximate Interval Betwo Onset and De	reen
.O. Box 6	at the death certifice by the attending physteched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3]Ectopic p	oregnancy specify)				23d. Date of deli Month	,	ear
S, D	signed be de	þ	Part II. Other significant conditions con	1	ulting in the u	nderlying	cause give	n in Part I.		l tobacco	use contribute to	the cause of decobably 4 Un	
al Record		Completed							per	is an opsy formed?	prior to death?	topsy findings av completion of cau	
f Vital	Physician: 1 rthis certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ER/Outpatier	nt 3 🗆 D	Othe Othe		Death (Check only		6 ☐Other (Spec	cify)	1
ion of	f fe		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f M	28c. Injury Work	at ? ∕es 2 □ No	28d. Describ	e how inju	ry occurred		
Division	를 들는 를	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, larm, str	reet, lacto	ry, office			(Street ar own, State	nd Number or Ru e)	ral Route Numbe	e <i>r</i> ,
	the Hospital hin 24 hours the Funeral upletely filled	Medical	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	e, date and p pinion, death o	lace, and due to the occurred at the time	e cause(s e, date an) and manner as d place, and due	stated. to the cause(s)	
	To th withir To th	Ž	29b. Signature and title of certifier	slan		25	D 3	_	/	29d. Da	te signed (Month	i, Day, Year)	
	X		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print)	المطا	70	RLUI		Bourn	lui rosa	
7	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 1 2006	32) Registrar's Signa	ature						1 1 1	-1 -1	

			For State Registrar		State of I	Maryland		irtment of tificate o			ental Hy	giene Reg. No.	006	17192
	Physicia	an	1. Decedent's Name (First, A Samuel C	diddle, Last)							2. Date of De Month May	27,	2006	3. Time of Death 10:42P M
	/Medic Examin		4a. Facility Name (If not insti	tution, give s		er)		4b. City, Town			may		ounty of Death	
			Good Samari 5. Social Security Number	tan Ho		Age (In yrs. Ia	st birthday)	Bo	utimo ar If Und		8. Date of Bi	rth	N/A 9. Birth	nplace (State or Foreign
	Funeral Director		220-05-3079		M 2□F	87	Yrs.	Months Day		Min.	8. Date of Bi (Month, Di Jan. 2	4, Year) 9	19 M	vryland
	land Dw		Usual Residence of Deceder 10a. State 10b. Co			10c. City,	Town or Lo	cation						10d. Inside City Limits
	e-fsh	ctor	Maryland Ba	ltimor	e			Overl	Lea					1 ☐ Yes 2 🙀 No
	with th	Dire	10e. Street and Number 518 Meadow	Road				10f. Zip Code		1206		10g. Citize	on of What Cou	-
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Modred Examinat must be modified at	Funeral Director	11. Marital Status		2. Was Decede	ent Ever in U.S	S. 13. V	Was Decedent of Yes, specify C			cify Yes or No	D- 14	. Race - Amer Black, White	ican Indian,
36	rs after	by Fu	1 Never Married 2 X		1 X Yes 2 If Yes, Give Year or Date	□No		l□Yes 21X			,		pecity: Wh	
21215-0036	72 hou natura	sted		edent's Educ	ation			lent's Usual Occ		ost of workii	na	16b. Kind	of Business/I	ndustry
121	within and than "	Completed	Elementary/Secondary (0-		College (1-4	or 5+)	life. L	DO NOT use ret	ired)			Free	state.	Transfer Co.
	2 should be filed within and Mental Hygiene. ia marked other than aumatic event, Ine M.	Be Cc	17. Father's Name (First, Mic				7-10-03		18. Mo		(First, Middle	, Maiden Su	umame)	
Maryland	should be and Mental a marked o umatic eve	To	Antonio	Casci			105 14-15-	- Add (Can-		ovann		Pau		To Code)
Ma	nd 2 sh lith and 27 ia n r traun		19a. Informant's Name/Rela Norma E. Cas		wife)		i	g Address (Stre Meadow				-		ip Code)
ore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event. It is M. Jical Ex. miner mail be notified at once.		20a. Method of Disposition 1 M Burial 2 □ Crema	tion 3 ∏Re	emoval from Sta	ate ce	metery, cren	sition (Name of natory or other p	· · · · · ·		ate		tion - City or 1	
Baltimore,	it. Pag itment irtant: I njury o		' 4 □ Donation 5 □ Oth	er (Specify)		Par		Cemeter. Name and Add	40					Maryland
Ba	permi Depar Impor any ir		Difau	نعان	Rine	Ren		7705 Bel						
8760, <	the death certificate be executed The death certificate be executed The attending physician and the attending physician and the attending period of	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or	as a consequ as a consequ as a consequ	ence of):	rrhy	TEN	na				
9	leath certifica attending ph I for use as th	an/Med	IF FEMALE:	. 2:	3c. If yes, outco	me of pregnar	ncv					22/	d. Date of deli	(80)
.O. Box	at the death of by the atten tached for u	Physician	in the past 12 months? 1 Yes 2 No 9 Unknown	11	1 Live birth	n 2 ∏ Fetal It at time of de	death 3[Ectopic pregna Other (specify)				200	Month	Day Year
rds, P	ires the signed d be de	by	Part II. Other significant co	nditions con	tributing to deat	th but not resu	Iting in the u	nderlying cause	given in Pai	rt I.		tobacco use Yes 2 1		the cause of death?
Records,	The ate has page	Completed									24a. Was auto perf 1 ☐ Yes		prior to c death?	opsy findings available ompletion of cause of
Vital	Phyaicien: T this certificat ral director, pa	o Be (25. Was case referred to me examiner? 1 Yes 2 No	-	lospital:	251	R/Outpatien		Othor		(Check only		☐Other (Spec	
of	Attending Phys r death. ector: After this by the funeral di	-	27. Manner of Death 1 ☑Natural 5 ☐ P	ending vestigation	28a. Date of		28b. Time of Injury	28c. Ir	njury at Vork?	2	28d. Describe			ny)
Division	tel or Attending P s after death. al Director: After led in by the funera	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined		Injury - At ho , etc. <i>(Specify</i>		eet, factory, offic	се	2	8f. Location (City or To	(Street and f wn, State)	Number or Ru	ral Route Number,
	To the Hospitel or / within 24 hours after To the Funeral Direction completely filled in b	Medical (ner: On the basi and manner	is of examinati		vestigation, in m	y opinion, d	eath occurre		date and pl	lace, and due	to the cause(s)
)	To t Within	M	29b. Signature and title of	ertifier	Con	1, mo			OT98	-0		29d. Date s	signed (Month	Day, Year) 0 2006
	6+1		Name and address of pe	erson who co	mpleted cause	of death (Item	23a) (Туре,	Print) Por	ven	Blvo	d ,	MDa	2/239	7
	Sta Regist		31. Date filed (Month, Day,			gistrar's Signat	ure	ede		pe				

ORIGINAL

			For State Registrar	State of Maryland		rtment of H			iene _{g. No} 2006	17193
2.			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	h Day Year	3. Time of Death
	Physicia /Medic		Clint	Н.		Cox		May	27, 2006	11:20P™
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Death	1
		<u>.</u>	115 Gambrills Ro			Sever			Anne	Arundel
В	Funeral		5. Social Security Number 6. Sex	10 OF F	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	82				Sept. 15	5,1923 Ten	nessee
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Many f sh	ğ	Maryland Anne Ar	ınde1 Se	evern					1 ☐ Yes 2 ☐ No
	the not	Je C	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	untry?
	3a o	Funeral Director	115 Gambrills Road			2	1144		U.S.A.	
	ms 2	Jere	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H I Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer Black, White	
စ္	or ite	F	1 ☐ Never Married 2 ☐ Married	t ∰Yes 2 ☐ No If Yes, Give		Tes, specify output	Specify:	5 · 110a11, 010.)	Specify	
ဗ္ဗ	ours irai',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	İ					White
ν. V	filed within 72 hours after death with the Maryland Hygiene. ther than natural, or items 23a or 28a-f show wit, tra Mazical Franti ar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of won	king	16b. Kind of Business/l	ndustry
7	within one.	d E	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		ngineman			II C Nove	
22	Hygie ther int, ii	ပိ	17. Father's Name (First, Middle, Last)	N/A	اتا	igineman		ne (First, Middle, A	U.S. Navy Maiden Sumame)	
an	d be ontal	o Be	Mynatt		Cox		Laura			Mixon
<u></u>	shout nd M mark	2	19a. Informant's Name/Relationship (Ty	oe, Print)		g Address (Street		ral Route Number,	City or Town, State, Z	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any figury or other traumatic event, the Medical Examination in the notified at angle.		Carol C. King (Da	ughter)	1762	West Dri	ve Pasado	ena. Marv	land 21122	
	r Hee f Hee item othe		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of natory or other place	1		20c. Location - City or T	Town, State
9	Pages ent of nt: if i		1 ☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ige Mem.		1/06 E	Elkridge Ma	rwland
Baltimore,	ortan inju		21. Signature of Funeral Service License			-				
ä	Depermine Suny is		I for F	Collens.	32	204 Mount	ain Road	nnerai no Pasadena	ome, P.A. a, Maryland	21122
- 7			23a. Part1 Enter the disease, or complishock, or heart failure. List only or	cations that caused the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CONC	4 ES	TIVE	= 41	EART	TAILUI	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	tence of):		1-0 >		015	
	Examiner		Sequentially list conditions	15CH6	MI	c C-	Mas	1 PWY	31/1-(H	7
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jence of):	NOV	HE	MAT	DISEA	CE
	and -trans	каш	that initiated events resulting in death) Last	Due to (or as a consequ	ience ot):			1	DIJEA	76
8760,	cate be executed physician and the burial-transit			545 (5) (5) 45 4 551,554	301.00 01).					
87	phys phys the	dical								
9 x	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	ncy				23d. Date of deli	verv
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	·		Month	Day Year
P.O.	y th	lys	1 Yes 2 No 9 Unknowh	9□ Unknown						
	res that signed b be deta	by Pi	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	quire on sig uld b							1 □ Ye	es 2□No 3□Pro	bably 4 Vunknown
ecords,	law requires that as been signed b 2 should be deta	Completed						24a. Was ar	n 24b. Were au	topsy findings available ompletion of cause of
Œ	The age	E						autops perforn 1 Yes 2		20 No
Vital	sician: certifica	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	-	
	d is	10	1 Yes 2 No		ER/Outpatier	it 3□ DOA Oth	er: 4 🗆 Nursing H	ome 5 Reside	nce 6 Other (Spec	ufy)
n of		Ë	27. Manner of Death t Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>			Yes 2 □No			
Division		Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str /)	eet, tactory, office		28f. Location (St.	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	ပိ	23s Certifier Curtifying Phy	Melan: To the best of my kno	ulada ta	to the second section to	as date and class	and due to the ea	and the same was a second	
	To the Hospital within 24 hours a To the Funereil completely filled	edical		ner: On the basis of examinal and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	5 10 5		29c. Licens	e number		9d. Date signed (Month	, Day, Year)
	F \$ F 0		· Mun	MANN		DC	0063	145	5/2	0/06
/	x V		30 Name and address of person who co	empleted cause of death (Item	23a)_[[vpe.	ितिnt)	1 1	1.1	7	
5	1		ARVIND D	ESAI 11	15	Koes	u Re	HU	m 13w	ume Mo
EQ.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	W				
40.	Regist	rar	JOH O T SOOO	poster 15	1					

Joyce clark

		Please I	State of Maryland					_	1 ~ 1 ~ 1
		For State	State of Maryland		rtificate of l			g. No.	1/194
*	- 8:	Registrar 1. Decedent's Name (First, Middle, Last))		inouto or i		2. Date of Death	g. 140.	3. Time of Death
Physicia	an		lene		Clark		May 1	Day 2006	5:09AM
/Medic Examin		4a. Facility Name (If not institution, give			0_0_	Location of Death	1 1	4c. County of Dea	
Examin	eı	Doctors Community			Lanham			Prince (Genroe's
Funeral		Social Security Number 6. Sep.	7. Age (In yrs. la	ast birthday)	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birl	thplace (State or Foreign
Director		248-21-6439] M 2 🕅 F 49	Yrs.	monard Bayo		Mar. 14,		
pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City	. Town or Lo	ocation				10d. Inside City Limits
laryla •ho	'n								1 X Yes 2 □ No
the N 28a-f	ect	Maryland Prince G	eorge's Lai	nham	10f. Zip Code		10	g. Citizen of What Co	puntry?
5-UUSO 72 hours after death with the Maryland natural; or items 23s or 28s-f ehow need Examinational by Inditional	Funeral Director	520 Eastern Avenue			20019			U.S.A.	•
death	era		12. Was Decedent Ever in U.S	3. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
or iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 🕅 No	1	IIYes, specify Cuba 1□Yes 2ሺNo	in, Mexican, Puerto Specify:	Hican, etc.)	Black, Whit	
5-UU36 72 hours at natural; or	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		TLI Fes ZENO	эрөспу.		Specify: Bla	ıck
72 hg	Completed	15. Decedant's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most of work	ing 1	6b. Kind of Business	/Industry
F e gr	Ig I	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired okkeepins	•		Uniform &	Cleaning
filed v Hygie Hygie othar t		17. Father's Name (First, Middle, Last)	J		ORRECPIN	18. Mother's Nam			Greating
d be f d be f ental h	Be	Wilford Ford					tine McO	- ,	
mark matic	2	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Maili	ng Address (Street			City or Town, State,	Zip Code)
Baitimore, Maryland 21215-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar then "natural", or items 23a or 28a-f ehow any injury or other treumatic event, the Madical Examinational Landillish at once.		Doris Clark (Sis		P.O.	Box 1251	Landove	r, MD 20	785	
Te, S 1 ar		20a. Method of Disposition	20b. Pl	ace of Dispo	osition (Name of matory or other place	ce)	Date 2	0c. Location - City or	Town, State
Page ent o nt: if		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	nemoval nom State	on Cen		5/20	/06 La	akeview, S	C
altimore, mit. Pages 1 a partment of Hes portant: if item y injury or othe		21. Signature of Funeral Service Livens	1-11	2:	Name and Address Bartell S	ss of Facility	Home		
n ggerg		Lennis Be	Mnew					sc 29536	
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the death ne cause on each line.	. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cordio	resi	uator	4 col	lapse		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequent	ience of):	1	1	1 .		1.000
CAMILINE	_	Sequentially list conditions,	b. Aortc Due to (or as a consequ		Ive ei	ido con	ditinis		weeks
ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or).					
60, be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):					
760 e be e sicier s burik	caiE	(d						
. Box 687 death certificate e attending phys ed for use as the			V						
BOX Bath cert attendin for use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Liva birth 2 ☐ Fetal		⊒Ectopic pregnancy	,		23d. Date of de	,
deatl deatl	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 🕱 No	4 Pregnant at time of de		Other (specify)			Month	Day Year
P.O	hys	9 Unknown							
	by	Part II. Other significant conditions co	· ·	ilting in the u	inderlying cause giv	en in Part I.		accoluse contribute to s 2 □ No 3 □ Pi	robably 4 XUnknown
require peen si	ted	Septic 8h	ock				1 10	2 2 10 3 11	
e 2 sl	Completed						24a. Was an autopsy	prior to	utopsy lindings available completion of cause of
							perform 1 Yes 2	No 1 ☐ Yes	2 X No
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be control.	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 X Inpatient 2 □ I		-t 20 DOA Oth	or	h (Check only one		
Division of Vita to Attending Physicien: after death. Director: After this certification by the funeral director.	5. To	27. Manner of Death	28a. Date of Injury	ER/Outpatie 28b. Time o	III 3 DOA	4 Nursing Ho	28d. Describe how	nce 6 Other (Spe w injury occurred	icity)
On th. :: Afte	tor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	k? Yes 2 No			
VISIO Attendi or death ector: A by the fu	illici	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R.	ural Route Number,
Is after or all Direction of the Color of th	Certification:		building, etc. (opoon)						
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	rsician: To the best of my know inar: On the basis of examinat	wledge, dear	th occurred at the tire	me, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29	d. Date signed (Mont	h Day Year)
F 3 F 8) (alat 1	MD	MD			5-17-	
69		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type	Print)				- C.
9		Nima H. Calat	7202 Qu	isint	verry Wa	zy. Dow	ix, MD	20720	
5.5 (A) . (SEE)	ate	31. Date filed (Month, Day, Year) JUN 0 1 2008	39. Registrar's Signal	ture	40	/	,		
Regist	rar	2014 A T 5006	plus D.	SO.	all I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 30, 2006 Medical Dr. Hugh Melvin Clement, Jr. DDS 12:05P M Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

	LAGITI	101	Saint Josep	h Medical	Center	r		Tow	son		Baltimore
	Funeral Director		5. Social Security Number 220-09-0687	6. Sex 7. A	Age (In yrs. last b		r 1 Year Days	If Under 24 H Hours M	in. (Month	Birth Day, Year)	Birthplace (State or Foreig Country) MD
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Balti	more		wn or Location					10d. Inside City Limit:
	3a or 28a	Il Director	10e. Street and Number 121 E. Pado				Code 2	1093		_	ol What Country?
036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Iteme 23a or 28a-f ehow event. The Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ied 1 TYes 2 If Yes, Give Year or Dates	s?	13. Was Dece If Yes, spe	cify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.	No- 14. I	Race - American Indian, Black, White, etc. ecify: white
21215-0036	within 72 ho piene. r than "natur the Medical.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		r 5+)	a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done d	uring most of v	working	16b. Kind o	of Business/Industry
Maryland 2	2 9 2 0	To Be C	17. Father's Name (First, Middle, 1	Last) I. Clement,	Sr.			Emi	ma Smit	ddle, Maiden Sun h	пате)
e, Mar	nd 2 suith ar 27 le		19a. Informant's Name/Relationsl Enrica C. Cleme		1	21 E. Pa	doni		Timoni	um, MD	
altimore,	permit. Pages 1 a Depertment of Hes Important: If item eny injury or othe		20a. Method of Disposition Burial 2 Cremation Donation 5 Other (S) 21. Signature of Functal Service	pecify)	e cemete	of Disposition (Na. ery, crematory or o	other place	emorial	/06 Garder		on - City or Town, State
Ba	Deperment of the contract of t		Michael J. F	lagle		Lemmo 10 W	n Fu	ineral donia R	Home of	Dulane monium,	y Valley, Inc. MD 21093
j.	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. METAS		CANCER				y arrest,	Approximate Interval Between Onset and Death
	certificate be executed and and physicien and use as the burial-transit.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence						
68760,	tificate be ig physicie as the bur			d							
.O. Box	death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	h 3 Ectopic pi 5 Other (sp					Date of delivery Month Day Year
s, p	res tha	by	Part II. Other significant condition		but not resulting	in the underlying o	ause give	n in Part I.		id tobacco use o	ontribute to the cause of death? 3 Probably 4 Unknown
of Vital Record	The la ete has page 2	Completed								utopsy erformed?	b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes
of Vit	Physicien: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat				r: 4 ☐ Nursing	Home 5 R	esidence 6 □0	Other (Specify)
Division (ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could in	pation not be 38 a Blace of le	fay Year)	Time of Injury M		at ? ′es 2 □ No		be how injury occ	
ο̈́	ਤੇ ਜ਼ਿੰਦ		4 Homicide determi	g Physician: To the bes	etc. (Specify)			e date and pla	City or	Town, State)	mber or Rural Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	Medical	(Check only one) 2 Medical to Medical to One)	and manner s	of examination at	nd/or investigation	, in my op	inion, death oc	curred at the tin	ne, date and plac	manner as stated. ee, and due to the cause(s) ned (Month, Day, Year)
)	~\		1	Horns				254		5/	30/06
	10,		30. Name and address of person v BOON P. LIM M 31. Date filed (Month, Cay Year)	.D. 7601	OSLER I	RIVE TO	DWSO	N MAR	YLAND (21204	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 20	106	trar's Signature	perte					

Physician

			1 - State of Maryland	/ Departme				iene 2 (06	17196
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h		3. Time of Death
	Physicia	an	Robert John	Cor	wan		Month	Day 7	2000	1510 PM
	/Medic		4a. Facility Name (If not institution, give street and number)			Location of Death	1.109	4c. Coun	ty of Death	1010
	Examin	er	31 1100 110	45.00	3011	- Ca		10.000	.,	
			5. Social Security Number 6. Sex 7. Age (In yrs. last	t hirthday) If Und	er 1 Year	If Under 24 Hrs.	8 Date of Birth		9 Right	place (State or Foreign
	Funeral		5. Social Security Number 6. Sex 1.2 M 2 F 51	Yrs. Months		Hours Min.	8. Date of Birth (Month, Day, Nov. 10,	Year)	Cour	ntry)
υ.	Director		Usual Residence of Decedent				NOV. IU,	1734	MD	
	Du A			Town or Location					1	0d. Inside City Limits
3	aryi h	៦	MD Baltimore	Halethor	ne.					1 ☐ Yes 2 🎇 No
	889-1	ect	10e. Street and Number		ip Code		1	0g. Citizen of	Mhat Cour	otni?
4	72 hours aller deeln with the Maryland Inatural, or Itema 23a or 28a-f ehow olcel Examiner must be nullified at	Director		101. 2		7				iti y :
4	1238	ra	808 Rambo Court		2122			U.S.		
7	e E	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hi ecify Cuba	spanic Origin? (Spen, Mexican, Puerto	Rican, etc.)		ace - Americ ack, White,	
2	alle or h	Ē	1 Never Married 2 Marned 1 Yes 2 No	1 🗆 Yes	2 X No	Specify:		Spec	ity: Whi	te
Dairillole, mai ylalid z iz 13-0000	iours	d by	3 ₩ Widowed 4 □ Divorced Year or Dates:							
5	nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Us (Give kind of w	vork done c	turing most of works	ng	16b. Kind of	Business/In	dustry
	within ene. then "	gu	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT)		_		
	e tiled within al Hygiene. cother then vent, its Mi	S	11	Longshor	eman					timore
	oth oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Suma	ime)	
	uld be Mental rrked o	ပို	Martin Cowan			Blanch ₀	2			
	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres	ss (Street a	and Number or Rura	il Route Number	City or Town	n, State, Zip	Code)
	and 2 ealth a m 27 is		Ms. Brandi Schalker/ Daughter	808 Rambo	Cour	t, Halet!	norme. M	0.2122	7	
	-IOF		20a. Method of Disposition 20b. Plac	e of Disposition (N	ame of	-) [ate	20c. Location		own, State
	Pages nent of int: if it		1 □ Burial 2X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ches	sapeake C	romat	" May (31,	tevens		MD
ď	artmen crtant: crtant: injury		21. Signature of Funeral Service Licensee	22 Name	and Address	s of Facility C=	1			
	permit. Page Department of Important: if any injury or phose.			75-71 Sec		ss of Facility Sin				
			23a. Part1. Enter the disease, or complications that caused the death.	9 1					עב ע	Approximate
										Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	-8V4	+a	there				8 hows
	/Medical		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	nce of):		,				Comments and
	Examiner		, metas ta	+ LC	ren	al cell	carci	MOM	a	6 month
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):						
	be executed sicien and burial-transit	Examine	Cause (Disease or injury that initiated events c.							
-	exec n an ial-tr	Exa	resulting in death) Last Due to (or as a consequen	nce of):						
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	ficate physics the	Physician/Medical								
	eath certific attending p	N.	IF FEMALE: 23c. If yes, outcome of pregnance	у				23d D	ate of delive	arv
	atter	ian	in the past 12 months?	eath 3 Ectopic					Month	Day Year
	at the de by the tached	ysic	1 Yes 2 No 9 Unknown 9 Unknown	11 3 G Other (:	3pecity/					
	The law requires that the death certificate be executed ten has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but not resulting	no in the underlying	Cause div	en in Part I	23e. Did tol	pacco use co	ntribute to ti	he cause of death?
	ires thai signed t	by	Charle of Drucht	638 - n.	1 .44		MO CIOY	_	3 Prob	
	w requir been si should	ted	CHAMIC OUSE , SECO		LIV	- wary ar.	ال ال	2 2 140	3/24 100	Jabiy 4 Conknown
	elawr hasbe je 2sh	Completed					24a. Was a autops		. Were auto	psy findings available mpletion of cause of
	The I	E					perform	ned? 2⊠No	death? 1 ☐ Yes	
		0	25. Was case referred to medical			26. Place of Death	- T			
	Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 X EP	VOutpatient 3 0	Othe Othe		me 5 Reside	700	ther (Specif	(v)
		<u> - </u>	27. Manner of Death 28a. Date of Injury 28	8b. Time of	28c. Injury		28d. Describe ho			<i>y</i> /
	Attending I or death. ector: After by the funer	Ę.	1 Accident investigation (Month, Day Year)	Injury M	Worl	k? Yes 2 □ No				
	death death ctor: / y the fi	ca	3 Suicide 6 Could not be 399 Bloom of laium. At home				28f Location /St	reet and Num	ober or Pur	al Route Number.
	or A fter Direction by	Certification:	4 Homicide determined building, etc. (Specify)	s, laim, sireet, lack	ury, ornos		City or Town		iber of Hura	ir roble reditiber,
i	urs a		200 0 45 25 25 25 25 25 25 25 25 25 25 25 25 25				0 88			
	Hosp Tune Bly fi	ca	29a. Certifier (Check only Medical Examiner: On the basis of examination	∌dge, death occurre π and/or investigatir	ed at the time on, in my of	ne, date and place, pinion, death occurr	and due to the ca ed at the time, d	ause(s) and n ate and place	nanner as si , and due to	tated. the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) and manner stated.							
	10 To	2	29b. Signature and title of certifier		9c. License			9d. Date sign	ed (Month,	2 00 L
	/		INVVIIV)	100	02731	> /	riuy	ny	2000
	1-		30. Name and address of person who completed cause of death (Item 2)	3a (Type, Print)	0.	Λ	11	-	3 1	7/1
	5		M. L. Fryden bory	mo	Siti	02731 Aque) fle	15000	tal	Dal din
	Str	ate	M. L. Fryken Dory 31. Date filed (Month, Day, Year) JUN 0 1 2006	0 / 40 -		1	•	0		
	Regist		JUN 0 1 2006 Steele 15	Appels?		7				

			For State Registrar		State of	Marylan	id / Depa	artment of H	ealth and Death	d Mental Hyg	giene 2 Reg. No.	006	17197
			Decedent's Name (First,	Middle, Lasi	t)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic	al	Conrad	W.	Czerw			41. Ch. T.	I casting of Do	Month May		Year 2006 Inty of Death	5:48AM M
1	Examin	er	4a. Facility Name (If not inst			n <i>ber)</i>		4b. City, Town, or		eatn			
	Formul		204 Highf 5. Social Security Number	alcon 6. Se		7. Age (In yrs.	last birthday)	Reister If Under 1 Year	If Under 24 H	Irs. 8. Date of Birt	h	Baltin 9. Birth	nore place (State or Foreign intry)
н	Funeral Director		217-22-2577	1	M 2□F	77	Yrs.	Months Days	Hours M	in. (Month, Day May 5,	y, Year)	Сои	(ntry) MD
	D		Usual Residence of Decede										
	urylar nhow	_	10a. State 10b. C	ounty		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8 -f. a	Director		Baltir	nore	Re	isters						
	with th	Dire	10e. Street and Number					10f. Zip Code			10g. Citizen	of What Cou	intry?
	s 23s	Funeral	204 Highfa	lcon I		dent Ever in U	e 12		21136	(Specify Ves or No.	. 14 [USA Race - Ameri	ican Indian
	item item	un-	11. Marital Status 1 □ Never Married 27€	Married	Armed For	rces?	.5.	If Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		Black, White	
336	urs af	by	3 ☐ Widowed 4 ☐ Div		If Yes, Giv Year or Da	0		1 ☐ Yes 2 🗓 No	Specify:		Spe	ecify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "natural", or items 23a or 28s-f ahow avent, it a Medical Examinat must be notified at	Completed by	15. Dec (Specify only	edent's Ed	ucation		16a. Dece	dent's Usual Occupa	ation	working	16b. Kind o	f Business/Ir	
218	thin 7	npie	Elementary/Secondary (0		College (1	-4or 5+)	life.	DO NOT use retired)	WOIKING			
	filed wi Hygien sther th	S	11				7	Varehouse		l			ibuting Co
lud	tal H	Be	17. Father's Name (First, M	iddle, Last)					18. Mother's I	Name (First, Middle,	Maiden Sun	name)	
Z	2 should be filed within and Mental Hygiene. ia marked other than eumatic avant, II a M	၉	John E. Cze			-	40h M-16	A dd (Ctt		na Novak	City of To	us Ctata 7	- Codo)
Maryland	12 sho h and 7 is mu treum		19a. Informant's Name/Rel			-				Rural Route Numbe			
	ges 1 and 2 should t of Health and Men if item 27 is marke or other treumstic		Mary C. Cze 20a. Method of Disposition	rwins	ki Wi	20b. F	Place of Dispo	sition (Name of		, Reister:		on - City or T	
Baltimore,	Pages nent of I int: if its iry or o		1 X Burial 2 ☐ Crem			State		matory or other place		. 10.10.		•	
Ħ			4 □Donation 5 □Ot		·	Eve		 Mem. Ga1 Name and Address 				-	m Road
Ba	Depertition Depert		1 Stool	an	m	Lenk	1, 1	line Fune					n Road 21136
			23a. Part1. Enter the disea	se, or comp	olications that c	aused the deat						wir, IID	Approximate
	Dhysisian		shock, or heart failure Immediate Cause (Final	. List only o	one cause on e	ach line.	E	0.1-12					Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)		a. Due to (or as a consec							7/3
	Examiner												
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a consec	quence of):						
V	nd cutter ransi	Examiner	that initiated events	•	c								
760,	te be executed ysicien and ne burial-transit	Ä	resulting in death) Last		Due to (or as a consec	quence of):						
876	2 2 2	Ilcai		•	d								
x 68	The law requires thet the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:		23c. If yes, out	comp of proces	2001						
Box	attend for us	ian/	23b. Was decedent pregna in the past 12 months	int	1☐Live b	inth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnancy Other (specify)			230.	Date of deliv Month	ory Day Year
P.0.	he de the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkno		Joann J						
	thet led by deta		Part II. Other significant co	onditions of	ontributing to de	eath but not res	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use o	contribute to	the cause of death?
Records,	puires n sign ald be	Completed by	Asc.	12)						101	res 2 Z	o 3□Pro	bably 4 Unknown
00	w requires been si	iete								24a. Was		b. Were aut	opsy findings available
Re	The la	E O								autop perfo 1 Yes	rmed?	prior to co death? 1 \(\subseteq \text{Yes}	ompletion of cause of
Vital		a	25. Was case referred to m	edical					26. Place of I	Death (Check only o		1 103	
Ž	Physician: this certificated fall director, I	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 🗆 I	npatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursin	g Home 5 Aesid	dence 6 🗆	Other (Speci	fy)
0	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 ■Natural 5 □ 1	ending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o			28d. Describe h			
<u> 0</u>	Attanding r death. ector: After by the fune	atic	2 Accident	nvestigation				M 1 🗆	Yes 2 □ No				
Division of	or Att	rtiff		determined	28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory, office		28f. Location (S City or Tox	Street and Nu vn. State)	ımber or Rur	al Route Number,
	pitei ours a erai I	Ö	29a. Certifier 17 Ce	rtifying Ph	veician: To the	hest of my kni	owledge deal	h occurred at the tin	ne date and of	ace, and due to the	cause(s) and	i manner as	stated
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical Certification:			niner: On the ba					ccurred at the time,			
	within To the compl	Me	29b. Signature and title of					29c. Licens			29d. Date sig		
			> Rul	1 1	Mr		00	03	288	2 2	5/	31/	96
	Le		30. Name and address of p	erson who			m 23a) (Type,	Print)	, and	1 1	Pens	1 for	06 , Ml 7/134
	Sta Regist		31. Date filed (Month, Day,	Year) 0 1 2		gistrar's Sign		perte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 91 2006 /Medical 4b. Gity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 05 OWN more 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 19, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖺 F 212-26-1660 89 Jan. MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f ehow other then "neture!", or iteme 23a or 28a-f ehovent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Baltimore Co. Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 1322 Greenwood Road USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Police Accountant other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Heelth and Mental I int: if item 27 is marked o Wilson H. Carter, Jr. May Gaigler ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart W. Carter - Son 16232 South 33rd Place, Phoenix, AZ 85048 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or o 13© Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 5-31-06 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD Approximate Interval Between Onset and Leath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician month 2 a St disease or condition resulting in death) a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760, use as the burial-tran ettending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 1 No Division of Vital Records, P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 Z No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) bacu Hospital: 1 ☐ Inpatient Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 🗌 Yes 2 🗷 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident the th 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 62912 May 28 2006 Road Randallstown 31. Date filed (Month, Day State Registrar

1 - For State Registrar

fatural Known as Irene chartate

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No.

3. Time of Death

	*		1. Decedent's Name (First, Middle, La	st)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		IRENE			CH/	ARKATZ		May	28	2006	10.23 AM
	Examin		4a Facility Name (If not institution, giv	e street and number)			4b, City, Town,	or Location of Death		4c. Co	ounty of Death	
			Sinai Hospital	of Ba	Item	orl	Baltin	nove let	1			N/A
	Funeral		5. Social Security Number 6. S			last birthday)	If Under 1 Year Months Day		8. Date of Bir	rth	9. Birthp	lace (State or Foreign
	Director		212-03-1624	□M 2 X F	88	Yrs.	Mortins Day	s Hours Will.	0772	3/1917	ÇOLI	MD
	D.		Usual Residence of Decedent									
	how		10a. State 10b. County		10c. City	y, Town or Loca					1	0d. Inside City Limits
	Ma F-	cto	MD BALTIN	10RE		BALTI	MORE					1 ☐ Yes 2 No
	h th	ie	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cour	
	23a c	ai	7202 ROCKLAND H	ILLS DRIVE	, #4	-01		21209				USA
	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow Alsal Exantinate Enrollifed at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. W	as Decedent of	f Hispanic Origin? (Suban, Mexican, Puert	Decify Yes or No	D- 14.	Race - Americ Black, White,	
9	after or its	교	1 Never Married 2 Married	1 ☐ Yes 2 💢	No	1	JYes 2∭X N		5 7 110di 1, 010.7	1		WHITE
03	ours :		3 X Widowed 4 ☐ Divorced	Year or Dates:			TIAS SMIN	o specity.		3)	pecify:	MILLIF
5-0036	s 1 and 2 should be filed within 72 hours f Heelth and Mental Hygiene. Item 27 le marked other than "natural", other traumatic event, the Medical Exa	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Decede	nt's Usual Occ	upation ne during most of wor	kina	16b. Kind	of Business/In	dustry
2	within ene. than "	пр	Elementary/Secondary (Q-12)	College (1-4or	5+)			ne during most of wor red)		ПОСТ	TTAL	
2121	d with giene. er thai	50	12			AUMIN	ISTRATO	IK .		пизн	PITAL	
	be filed tal Hygi d other event,	Be (17. Father's Name (First, Middle, Last))			18. Mother's Nan		, Maiden Su	ımame)	
<u>a</u>	thould be filed within Ind Mental Hygiene. marked other than matic event, the Mi	To	HARRY			DAVIS		MARGAR	ET			SMITH
Maryland	and P	13	19a. Informant's Name/Relationship (Type, Print)		-		et and Number or Ru				Code)
Σ	and 2 leelth a m 27 I		JOEL CHARKATZ /	SON		8221 I	MARCIE	DRIVE - B	ALTIMORI	E, MD	21208	
ē,	ges 1 and t of Heelth If item 27 or other to		20a. Method of Disposition		20b. P	lace of Disposi emetery, crema	tion (Name of	lace)	Date	20c. Loca	tion - City or To	own, State
Ę	Pege ent o nt: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special						/30/06	BA	ALTIMORE	E, MD
Baltimore	permit. Peg Depertment Important: eny injury o		21. Signature Funeral Service/Lice		1				OL LEVI			
Ã	permit. Depertrimports eny inju		> Janalar			8	900 RFT	STERSTOWN				
			23a. Part J. Enter the disease, or com	plications that cause	the deat							Approximate
			shock, or heart failure. Est onty Immediate Cause (Final	one cause on each li	ne.	0-0	6					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		epsi	7					days
	Examiner			Due to (or as	a conseq	uence of):	ha	wel to	imor	_		4 1.4
		1	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consec	neuce of).	. 00	wer m	MICHO		-	Cays Man
	bed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (0. 00		331.03 017.						750.00
	and I-trar	хап	that initiated events resulting in death) Last	c. Due to (or as	a consec	neuce of).						
60,	cien cien											
68760,	reate be executed physicien and s the burial-transit	양		_ d								
9 ×	that the death certificate be execu ed by the ettending physicien and detached for use as the burial-tra	clan/Medical	IF FEMALE:	23c. If yes, outcome	of progns	1001						
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	Ideath 3□E	ctopic pregnar			230	 d. Date of delive Month 	ery Day Year
	e de the e	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of a	eath 5∐0	Other (specify)					•
P.0	res that the de signed by the e be detached t	Physic	Part II. Other significant conditions			ultina in the con-	lashina sawa	maria Bank	220 Did	tahaana waa		ne cause of death?
	Se C 90	ρ	Part II. Other significant conditions	contributing to death t	iut not res	uiting in the und	eriying cause	given in Parti.				
ğ	w requires been sign should be	ed					-		יוי	Yes 2	No 3 Proc	ably 4 Unknown
သို	aw r as be 2 sh	Completed							24a. Was	an :	24b. Were auto	psy findings available mpletion of cause of
ď	The I	E							perfe 1 ☐ Yes	ormed? 2 X No	death? 1 ☐ Yes	2 No
of Vital Records,	ë i≌ ⊊	a)	25. Was case referred to medical					26. Place of Dea				7
>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 🗆	ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome 5□Res	idence 6	Other (Specif	v)
6	€ € €		27. Manner of Death	28a. Date of Inju		28b. Time of	28c. In		28d. Describe			,,
9	nding F ith. : After e funer	읊	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y rear/	Injury		vonk? □Yes 2□No				
Division	Attender death	#C	3 ☐ Suicide 6 ☐ Could not b	289. Place of in	ury · At he	ome, farm, stree	at, factory, offic	:e	28f. Location	Street and I	Number or Rura	I Route Number,
Ρį	Hospital or Attendi 24 hours efter death. Funerel Director: A etely filled in by the fu	Certification:	4 Homicide	building, e	ic. (Specif	y)			City or To	wn, State)		
	spits yours nerel	a C		nysician: To the best								
	Hos 24 hc Fun etely	dical		miner: On the basis of and manner st	t examina							

State Registrar 29b. Signatu

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ADAMS

JUN 0 1 2006

	1 - For State Registrar 1. Decedent's Name (First, Middle, L	actl		Certificate o	f Death	2. Date of Dear	eg. No. 2	006	3. Time of Death
ian cal	1. Decedent's Name (Pirst, Middle, L		ALAN	С	00K	Month MAY	Day Ju	Year 2006	11:23 A
ner	4a. Facility Name (If not institution, go	Dalt'		11.	, or Location of Deat	41	4c. Cou	nty of Death	N/A
		Sex 7. A	ge (In yrs. last bii	thday) If Under 1 Ye			Vaari	9. Birthpl	ace (State or Forei
	217-56-5687 Usual Residence of Decedent	1 M 2 □ F	60	Yrs. Months Day	s Hours Min.	M8731	/1945	Count	MD MD
_	10a. State 10b. County		10c. City, Tow					10	od. Inside City Limit
recto	MD N,	/ A	В	ALTIMORE		1	Og. Citizen	of What Count	1 X Yes 2 N
al Di	7054 SURREY DR	IVE			21215				USA
Funeral Director	11. Marital Status 1 🕅 Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 ☐ Yes 2 🛭	?	If Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		łace - America Black, White, e	etc.
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 □ Yes 2 🛣 N	lo Specify:		Spe		WHITE
Completed	15. Decedent's l (Specify only highest g	rade completed)		Decedent's Usual Oct (Give kind of work do life. DO NOT use ret	ne during most of wo	rking	16b. Kind of	Business/Ind	ustry
Com	Elementary/Secondary (0-12)	College (1-4o	N	IONE			NONE		
Be	17. Father's Name (First, Middle, Las MEYER	sussma	N	COOK	18. Mother's Nar	ne <i>(First, Middl</i> e, <i>I</i> BETH	Maiden Sum		SWANGER
₽	19a. Informant's Name/Relationship	(Type, Print)	191	. Mailing Address (Stre	et and Number or Ru	ıral Route Number		vn, State, Zip	
	ADELE COOK / S	ISTER		054 SURREY f Disposition (Name of	DRIVE - E			21215 in - <i>C</i> ity or Tov	wn State
	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cometa	ry, crematory or other p	P CEM 05/3			TIMORE	
	21. Signature of Funeral Service Lic		11231121	22. Name and Ad	ress of Facility	SOL LEVIN	ISON &	BROS.	, INC.
	23a. Part1. Enter the discase, or co	molic tion that cause	ad the death. Do		ISTERSTOW			VILLE,	MD 21208 Approximate
	shock, or heart failure. List on Immediate Cause (Final	y one cause on each	line.	not onto the mode of t	y mg, saam as sanaa	o or roopiratory and	000,		Interval Between Onset and Death
	disease or condition resulting in death)	a	s a consequence	of):					
e	Sequentially list conditions,	b. — Due to (or a	s a consequence	of):					····
Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
m	resulting in death) Last	Due to (or a	s a consequence	of):					
ledic		d							
by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 Fetal death at time of death	a 3 ☐Ectopic pregna			1	Date of deliver Month	ry Day Year
hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death	o □ Other (specify)					
	Part II. Other significant conditions NEWRODA	contributing to death	but not resulting i	n the underlying cause	given in Part I.		bacco use co es 2□No		e cause of death?
eted		lar perito	neal	shunt		24a. Was a	-		sy findings availab
Completed	7. 7.0.7	, ,		<u></u>		autops perforr	SV .	prior to corr death?	pletion of cause of
Be	25. Was case referred to medical examiner?	Hospital:		5-3	1than	ath Check only on	10/		
2	1 Yes 2 No 27. Manner of Death	28a. Date of In	jury 28b.	Thatient 3 DOA	ury at vork?	lome 5 ☐ Reside)
atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		ay rear)		Vork? ☐Yes 2☐No				
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 200. Flace of I	njury - At home, fa etc. (S <i>pecify)</i>	arm, street, factory, offi	>8	28f. Location (St City or Town	treet and Nu n, State)	mber or Rural	Route Number,
	29a. Certifier 1 Certifying F	Physician: To the bes	of examination ar	e, death occurred at the	time, date and place	a, and due to the curred at the time of	ause(s) and	manner as sta	ited.
Medicai	one) 29b. Signature and little of certifier	and manner	stated.		nse number			ned (Month, D	
	• //	LUV	W>	D	00634	166	Mar	128	2006
	30. Name and address of person with				1.6		1000	1	
	JOHN 141. 8	4DAMSK	1	inai no	COITEL	T	011	MARIE	

Astient Knewn and Michael Cock
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar		State	of Marylar			of Health an of Death	d Mer		iene 2	006	17201
			1. Decedent's Name (F	irst, Middle, I	Last)	<i>(</i> 1)	06.00	1. 1	^	2.	Date of Deat	h Day	Year	3. Time of Death
	Physicia /Medic		200	TIM		C	SEN	IN	<i></i>	^	NAY	27	DOOL	0 1926 M
	Examin	er	4a. Facility Name (If no.				(or orna		own, or Location of D				unty of Death	_
			HOWARD C 5. Social Security Number		1 GENE	7. Age (In yrs.		If Under 1	Year If Under 24		Date of Birth	IT	OWAY	nplace (State or Foreign
	Funeral Director		none	501	1 □ M 2 X F	7.7.go (117)75.	O Yrs.			Min.	(Month, Day,	Year)	Col	untry)
-	ט		Usual Residence of De	cedent							May 27	, 2006		Maryland
	anylan show	_	10a. State 10	b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 X No
	188-10	ecto	Maryland		Howard			101 7:- 0	Columbia	.		On Object	- 4 14 /h - 4 C-	
	with t	Ö	10e. Street and Numbe					10f. Zip C	2104	4.4	'	og. Citizer	of What Cou	,
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Staff ehow stiter than "natural", or items 23a or 28a-f ehow ent, the Madical Examiner must be multified at	Funeral Director	6416 Lochr	nage Ra.		cedent Ever in U		Vas Decede	nt of Hispanic Origin	? (Specify	Yes or No-	14.	Race - Amer	
0	after o	표	1 Never Married	2 Married	Armed F 1 1 Yes If Yes, G	2 No	+	Yes, specif	iy Cuban, Mexican, P X No <i>Specify</i> :	uerto Rica	an, etc.)		Black, White	, etc.
2	irai', c	d by	3 Widowed 4	Divorced	Year or	Dates:		1 1 1 es 2	ы по <i>эреспу.</i>			Sp	ecify:	White
2	"natu	Completed	15 (Specify o	. Decedent's only highest	Education grade completed)	(Give	lent's Usual kind of work OO NOT use	done during most of	f working		16b. Kind	of Business/l	ndustry
7	withir ene. than	m d	Elementary/Seconda		College	(1-4or 5+)	<i>"</i> 10. L	JO 140 1 230	never worke	d	ļ		neve	r worked
2	Hygi other	a)	17. Father's Name (Fire	one st, Middle, La	ist)				7		irst, Middle, I	Maiden Su	тате)	
0	iould be if Mental narked c	To B		Alle	n Cosentin	0					L	aura H	epfer	
2	and N		19a. Informant's Name	/Relationship	(Type, Print)		19b. Mailin	g Address (Street and Number o	or Rural Ro	oute Number	City or To	wn, State, Z	ip Code)
≥	and sealth m 27		Mr. Allen		ino	Father			chridge Rd. Co					
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be intilited at once.		20a. Method of Disposi	remation 3			Place of Dispo- cemetery, cren	natory or oth	er place)	Date	Va	20c. Locat	ion - City or 1	own, State
	it. Pa rimen ritant: njury		4 Donation 5			2007/3	Colum		norial Park). .(10		Clarksvill	e, Maryland
0	permit. Departi Importi any inj		21. Signature of Funer	I	101	SIOM L		_	–	Home. I	P.A.			
i			23a. Part1. Enter the c shock, or heart fa	disease, or d	implications that	caused the deal	th. Do not ente	er the mode	871 Old Colun of dying, such as car	n <mark>bia Pi</mark> rdiac or re	ke Ellicot	t City, I	MD 2104	3 Approximate
	Physician		immediate Cause (Fin	ailure.YList or al	nly one cause on	each line.	1							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a. Due to	(or as a consec	quence of):							
	Examiner		Sequentially list condit	ions	6 EX	treme	. Pre	mat	wity					38 minutes
	d ii	Examiner	if any, leading to imme cause. Enter Underlyin	ediate ng	Due to	(or as a consec	quence of):	a 1.4	ture of	010		کسر میں		21
_	and I-tran	хаш	Cause (Disease or inju that initiated events resulting in death) Last		c. Due to	(or as a consec	we of):	KUST	nue vi	1110	ius io	we s		3 hours
0/00	cete be executed physicien and the burial-transit	dicai E				•	,	•						
00		00 1			0									
Š	death certif e attending id for use as	M/M	IF FEMALE: 23b. Was decedent pro			utcome of pregnation		Ectopic pre	nancy			23d	. Date of deliv	,
- -	e deat he att	Physician/M	in the past 12 mo			nant at time of c		Other (spec					Month	Day Year
<u>ر</u>	d by t	Phy	9 Unknown Part II. Other significa	nt condition	e contributing to	death but not res	sulting in the ur	derhing ca	use given in Part I	· · ·	23e Did tol	acco use	contribute to	the cause of death?
Š,	w requires that the death certif been signed by the attending should be detached for use a	d by	Tate II. Othor Olgimion		o contributing to	doda Dat Hot To	January III tilo di	loonying car	230 givoir iir i ait i.			s 2 🔂		bably 4 Unknown
Ö	w requ	ete									24a. Was a	2	4h Were aut	topsy findings available
Ě	has has	Completed								-	autops perforr	y ned?	prior to death?	ompletion of cause of
VII	ilcien: Th certificate rector, pag	0	25. Was case referred	to medical					26. Place of	Death (C	1 ☐ Yes 2 heck only on	e)	T Tes	2□ No
	Physicien: r this certific ral director,	To B	examiner? 1 Yes 2 No		Hospital:	inpatient 2 □	ER/Outpatien	t 3□ DOA	Other: 4 Nursin	ng Home	5 🗆 Reside	nce 6	Other (Spec	ify)
o u	af e		27. Manner of Death 1≫Natural	5 Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury		c. Injury at Work?		. Describe ho	w intury or	ccurred	
<u>s</u>	Attending ir death. ector: After by the fune	cati	2 Accident 3 Suicide	investiga: 3 ☐ Could no	t bo	and lainer. As h		М	1 ☐ Yes 2 ☐ No		Location (Ct			
UNISION	i or A	Certification:	4 Homicide	determin	ed 259. Flat buil	ce of Injury - At h ding, etc. (Speci	fy)	eet, ractory,	οπισθ	201.	City or Town	, State)	umber or Au	ral Route Number,
	To the Hospitel or Attendii within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1	≰ Certifying	Physician: To the	ne best of my kno	owledge, death	occurred at	t the time, date and p	place, and	due to the ca	ause(s) and	d manner as	stated.
	in 24 he Fu pletel	edical	(Check only 2 [one)	Medical Ex	and ma	basis of examina nner stated.	ation and/or inv	estigation, i	n my opinion, death o	occurred a	at the time, da	ate and pla	ice, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title	of certifier	-111		10		License number		2	9d. Date si	gned (Month	, Dey, Year)
			P	rus	CULX	. ^\	110		7 42,114	+	1	TIAY	27	2000
	\		30. Name and address	of person with	no completed car	use of death (Iter	m 23a) (Type,	Print)	sell 201	0#1	02. (lack	SVILLE	JOOG PROKAM,
	Sta	te	31. Date filed (Month,		32.	Registrar's Sign	ature /	M.	Jul (-000C	(<u>-1</u> C	~	31.116	1
	Registr		JUN	0 1 20	06	IS SE	San San							

		1	For State Ragistrar		State o	f Marylan				lealth and Death	Mental Hy	/giene Reg. No.	2006		7202
\$ 1. - 1. - 1.	Physicia /Medic	an	1. Decedent's Name (First	t, Middle, Last)			COSE	EN'	Tin	50	2. Date of D Month MAY	eath Day	200		Time of Death
	Examin	er	4a. Facility Name (If not in			AL Ho!	SECTAL	, .		r Location of Deal	th		County of Dea		ς,
	Funeral		5. Social Security Number	6. Sex	1	7. Age (In yrs.		If Under	1 Year Days	If Under 24 Hrs Hours Min					(State or Foreign
	Director		none	1 🗆	M 200 F		O Yrs.	MONTHS	Days	2		7, 200(aryland
	D >	-	Usual Residence of Decer 10a, State 10b.	County		10c Cit	y, Town or Lo	cation			- Ividy 2	, 2000			nside City Limits
	aryla shor	7	Toa. State	County		, ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	oution,							I □Yes 2 No
	Ne M	Director	Maryland 10e. Street and Number	Hov	ward			10f. Zip		Columbia		10a Citi	zen of What C	Country?	
	with i	۵		Б.				101. 21	, 0000	21044		. ogi om		J.S.A.	
	ns 23	eral	6416 Lochride		2. Was Dece	edent Ever in U	.S. 13. V	Vas Dece	dent of h	lispanic Origin? (5	Specify Yes or N	0-	14. Race - Am		ndian,
36	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depriment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, I'm Medical Examination for notified at another.	by Funeral	1 Never Married 2	2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2.MNo ∕e	11	Yes, spe	cify Cub	an, Mexican, Puei Specity:	to Rican, etc.)		Black, Wh Specify:		hite
21215-0036	hour tural'	ed b		Decedent's Educ	Year or D	ates:	16a, Deced	lent's Usu	al Occur	pation		16b, Ki	nd of Busines		
<u>.</u>	in 72 "na fection	Completed	(Specify onl	ly highest grade	completed)	1.4==5.\	(Give	kind of wo	rk done	during most of wo	orking			er wor	
72	iene.	mo	Elementary/Secondary NON		College (1	1-40r 5+)			ne	ver worked			TIC V	CI WOI	RCU
D	illed Hyg othe	BeC	17. Father's Name (First,							18. Mother's Na	me (First, Middl	e, Maiden	Sumame)		
Maryland	uid be Aenta rked tic ev	To B		Allen C	osentino)						Laura	Hepfer		
ary	2 should and Men is marks sumatic		19a. Informant's Name/R	telationship (Typ	oe, Print)		19b. Mailin	g Address	s (Street	and Number or R	ural Route Num	ber, City o	r Town, State,	Zip Cod	(e)
	and 2 palth n 27 l		Mr Allen (Cosentino		Father				ge Rd. Colu		7			
ம	of He		20a. Method of Dispositio		emoval from		Place of Dispo cemetery, cren	sition (Nai na <i>tory</i> or o	me <i>of</i> other pla	ce)	Date	20c. Lo	cation - City o	r Town, S	State
<u>Ĕ</u>	Pages ment of ant: if it ury or o		4 Donation 5 C				Colum	bia Me	moria	I Park	1-06		Clarksvi	lle, Ma	aryland
Balt	permit. Departinimporta any inju		21. Signature of Funeral	Service License	alak	mol +	293 22		Slack	ess of Facility Funeral Hor	me, P.A.	11 0:1	MD 040	40	
U.			23a. Part1. Enter the disc shock, or heart failu	ease or complic	cations that o	aused the dear	th. Do not ent	er the mod	3871 de of dyi	Old Columb ng, such as cardia	a Pike Ellic ic or respiratory	ott City arrest,	, MD 210	App	proximate erval Between
М	Physician		Immediate Cause (Final	ire. List only on	^	Viabili									set and Death
	/Medical		disease or condition resulting in death)	a		(or as a consec									
	Examiner		Casuantially and appoint		EX	heme	Pren	ratu	int	4				90	minutes
7	D =	ner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ate	Due to	(or as a consec	quence of):	/ 50mm		of me					1
V	ocuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С	PHO	watu	re Ru	untu	re	of rue	Mond	ies		7	hours
Ö,	e execian a		resulting in death) Last		Due to	(or as a consec	quence of):								
8760	cate be executed physician and the burial-transit	dical		d											
9	entific ding p	0	IF FEMALE:	2.	3c If yes ou	tcome of pregn	ancv						and Date of d	eli .e.e.	
Вох	that the death certifi ed by the attending I detached for use as	Physician/M	23b. Was decedent preg in the past 12 month	mant	1 ☐ Live t	ointh 2 Feta	al death 3	Ectopic p		у			23d. Date of d Month	Day	Year
Ö	the de y the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unkn		Jean J) Ott 161 (3)	Decity/_						
α.	res that ti igned by be detac		Part II. Other significant	conditions con	tributing to d	eath but not res	sulting in the u	nderlying	cause gr	ven in Part I.	23e. Did	tobacco L	se contribute	to the ca	ause of death?
Records,	Se Co	d by									1 🗆	Yes 2	≌ 1No 3 □ F	robably	4 Unknown
Ö	w requir been si should I	Completed									24a. Wa	s an	24b. Were	autopsy f	findings available
Re	0 4 6	m d									aut per	opsy formed?	prior to death?	complet	tion of cause of
a	ician: Th certificate ector, pag	ပိ	25. Was case referred to	medical						26 Place of Do	1 ☐ Yes eath (Check only		1 □ Ye	s 2 🗆	No
Vital	Physician: this certific al director,	o B	examiner? 1 ☐ Yes 22 No	-	ospital:	Inpatient 2	EB/Outnatien	t 3 D	OA Ot	nac	Home 5 ☐ Re		6 □Other /Sn	acifu)	
of		-	27. Manner of Death	-	28a. Date	of Injury	28b. Time of		28c. Inju		28d. Describe			oury/	
o	Attending r death. ector: Afte by the fune	atio	1 Matural 5 ☐ 2 ☐ Accident	Pending investigation	(MQI	nth, Day Year)	Injury	м		rk?]Yes 2∐No					
Division	or Attencation death Director:	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place build	e of Injury - At h	nome, farm, str	eet, factor	y, office			(Street an	d Number or I	Rural Roi	ute Number,
	Ital or A rs after al Dire	Cer													
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical			nar: On the b	asis of examin ner stated.	ation and/or in	vestigation	n, in my	me, date and place opinion, death occ	curred at the time	, date and	place, and di	ue to the	
	To the I within 2 To the I complet	Me	29b. Signature and title	of certifier/	()			29	c. Licen	se number		29d. Da	e signed (Moi	nth, Day,	Year)
	0		► CIIIV	well.	X	MD			0	45714	•	MA	4 27		2006
	1		30. Name and address of			se of death (Ite	m 23a) (Type,	Print)	.11	, , #10	on Ola	10.0	1. 11	0 -	10.10
	1		Christine	Richar		5005	Signal	Lbe	LA.	lane"	12, vais	EZVII	16, 100	, 9	4027
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sta Regist	ate rar	31. Date filed (Month, Da	Y (Year) 200	6	Registrar's Sign	ature V	arke	•	se number 45714 Lane#10					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gilbert William Dabrasky 28 2006 4:55 a M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore 1817 Wilhelm Street 8. Date of Birth (Month, Day, Year) Mar 6, 1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 1 2 M 2 ☐ F **Funeral** 74 216-28-9705 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene is the Health and Mental Hygiene than "nature!", or Itama 23e or 28e-f ehow other traumatic event, the Medical Examblar multiple notilities at 1X Yes 2 No Baltimore Directo Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21223 1817 Wilhelm Street Funerai Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 GYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Painter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Madeline Schalitsky Gilbert S. Dabrasky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depertment of Health and Importent: If Item 27 is n any Injury or other traun 1825 Wilhelm Street, Baltimore, Maryland 21223 Cheryl A. Dabrasky / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/2/2006 Crownsville, Maryland Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funecal Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Parti. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART **Physician** /Medical Due to (or as a consequence of): Examiner DAR-CONO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year signed by the el 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 22 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N45643 06 has 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2129 SSO (ZEDWOOD) 14ELENE -MARK 419 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 0 1 2006

	•	State Registrar	ate of Marylai			of Death			Reg. No.	006	17204
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Vernon George Disn	ey					Date of De	Day 28	2000	3. Time of Death
Examine Funeral Director		4a. Facility Name (If not institution, give street SAL NT AGMS H 5. Social Security Number 213–16–3217	SPLTA 7. Age (In yrs	. last birthday) 5 Yrs.	BAU If Under 1	wn, or Location of WWW Year If Under 2 Jays Hours	E	. Date of Bir (Month, Da Sep • I	4c. Co	N/A 9. Birt	nplace (State or Foreign untry) aryland
	or	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. C	ity, Town or Lo	cation Baltim	ore					10d, Inside City Limits 1 Yes 2 No
uth with the Marylan 23s or 28s-f show wat be notified at	Director	10e. Street and Number			10f. Zip Co				10g. Citizer	of What Co	untry?
ath wi	rai	534 Parksley Avenu		10 40 1		21223	-0./0	(nited Race - Ame	States
15-0036 n 72 hours after dea	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in Umed Forces? XYes 2 □ No 8— Yes, Give Year or Dates: 12	1942	Yes, specify	t of Hispanic Orig Cuban, Mexican, No Specify:	Puerto Rio	can, etc.)		Black, White	
Maryland 21215-0036 As should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 In marked other then "natural", or Itama 23a or 28a-1 ahow traumatic event, the Madical Exertinal frequition	Completed by	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) 8	n npleted) College (1-4or 5+)	(Give	OO NOT use i	done during most	•		16b. Kind	of Business/ ings Brew	·
Ind 212: be filed within that Hygiene.	Be	17. Father's Name (First, Middle, Last)					•		Maiden Su		
Aarylan 2 should be and Mental 1 e marked raumatic ev	ို	Edward Gordon Disn 19a. Informant's Name/Relationship (Type, F		19b. Mailin	g Address (S	treet and Number	_	ret Sc		own, State, Z	ip Code) _ 28754
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a a a a a		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remove 4 □ Doftation 5 □ Other (Specify)	val from State Me	Place of Dispose competery, compared adowrld morial	sition (Name Patory or othe Park	of or place) 5-	Dat -31 -2 (ion - City or idge,	
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68760, ficate be executed physicien and is the burial-transit and	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conse								
Box 6 eath certific	Completed by Physician/Med	in the past 12 months?	yes, outcome of pregn □Live birth 2 □ Fet □ Pregnant at time of □ Unknown	al death 3 🗌	Ectopic pregr Other (special				23d	. Date of deli Month	very Day Year
rds, P.	ed by Pr	Part II. Other significant conditions contribu	ting to death but not re	sulting in the un	nderlying caus	se given in Part I.			obacco use Yes 2 🗆 N		the cause of death?
Division of Vital Records, P.O. I or Attanding Physician: The law requires that the dather death. Director: After this certificate has been signed by the sin by the funeral director, page 2 should be detached.								24a. Was autor perio 1 Yes	an 2 osy med? 2 No	4b. Were au prior to death?	opsy findings available ompletion of cause of
f Vital ysician: T	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	tal: 1 □ Inpatient a	SER/Outpatient	1 3□ DOA	Othor		Check only o		Other (Spec	ifu)
Sion of Vita tending Physicien: leath. tor: After this certific the funeral director,	On: 1	27. Manner of Death 28	la. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	280		now injury oc		
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A compile lety filled in by the fu	Certification:	2 Accident investigation	Be. Place of Injury - At I building, etc. (Speci	nome, farm, stre	M eet, factory, or	1 ☐ Yes 2 ☐ N		Location (S City or Tox		umber or Ru	ral Route Number,
DIVI To the Hospital or At within 24 hours after or To the Funeral Direc	Medical C	29a Cartifier 1X Cartifying Physician (Chack only one) 1 Medical Examiner:	or To the best of my kn On the basis of examin and manner stated.	icwladga, daath ation and/or inv	scourred at trestigation, in	he time, data and my opinion, death	place, and occurred	due to the at the time,	saus 3(s) ar date and pla	d manner as ice, and due	statad. to the cause(s)
To th within To th comp	ž	29b. Signature and title of certifier	4.4			icense number				gned (Month	
		20 Name and address of		m 22c) /T		2438528	8322	3	MAY	28,2	006
10+1		30. Name and address of person who comple	ME 9	00 CAT	DN A	VEILLE	BAY	IIIm	oce i	MD 2	1229
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					,		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Travis Stephen Dyer 1- For State Certificate of Death Registrar Decedent's Name (First, Middle.Last) 2. Date of Death Physician/ Month 0650 hrs Medical Examiner May 30, 2006 DYER TRAVIS c County of Death 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) WB Rt. 100 @ Lake Waterford Road Pasadena Anne Arundel 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Foreign Maryland Months Days Hours 30.1979 Director 214-04-9670 26 Nov. 1 X M 2 F Usual Residence of Deceden 10d Inside City Limits Oc. City, Town or Location 10a State 1 Yes 2 X No Pasadena 23a or 28a-f show Maryland Anne Arundel 28a-f show Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21222 U.S.A. 761 219th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 1 Never Married 2 X Married 2 X No Yes Specify: White 1 Yes 2 X No specify: Divorced If Yes Give Year is marked other than "natural", atic event, the Medical Examiner ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Technician Heating & A/C Co. 0 17. Father's Name (First, Middle, Last) 18 Mother's Name (First_Middle_Maiden Surname) Stephen Dyer Letitia S. Engles Be umatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 219th Street, Pasadena, Maryland 21122 Melissa L. Dyer (Wife) 761 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State or other Woodlawn Cemetery 06-03-06 Baltimore, Maryland Department o Donation 5 Other Specify 21. Signature of Funeral Service Licenses Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause in each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical tending physician a use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o ð 1 Yes 2 V No 3 Probably 4 Unknown Completed of Vital Records, 24b. Were autopsy findings available 24a Was an peen prior to completion of cause of autopsy has performed? death? 2 ✓ Yes 2 No 1 🗸 Yes Nο 26 Place of Death (Check only one) 25 Was case referred to medical Be Other₄ examiner? Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other, Scene this 1 V Yes ဥ 2 28c. Injury at Work' 28a. Date of Injury FOUND: 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury Driver auto fixed object collision FOUND: Natural 1 Yes 2 V No 5 Pending death Director: May 30, 2006 0650 hrs Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) WB Rt.100 & Lake Waterford Road, Pasadena, determined within 24 hours at To the Funeral L (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated 29c License number 29d Date signed (Month, Day, Year) 29b. Signature and title of cert O.C.M.E May 31, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year) Registrar's Signature

ORIGINAL

State Registra

		,	1 - For State Registrar	State of Maryland / I	Certificate of			ne . No. 200	5 17206
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) KATHARINE KNAP	P deVILLIERS-	CHUBET			2 ⁷ 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s ROLAND PARK PLACE)			, or Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 217-14-2026 1□	M 25 F 89		ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	^{9. Bir} 1916 MA	thplace (State or Foreign ountry) RYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	a-fah	ctor	MD	BAL	TIMORE				1 Xves 2 □ No
	vith th	Dire	10e. Street and Number	- m	10f. Zip Code		_	. Citizen of What C	ountry?
	na 23e	Funeral Director	830 WEST 40th	2. Was Decedent Ever in U.S.	212	L L L of Hispanic Origin? (Spuban, Mexican, Puerto		USA 14. Race - Am	erican Indian,
020	spes 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. if it itam 27 is marked other than "natural", or itema 23a or 28a-f ahow or other than "natural", or other traumatic avent, it a Macilial Examinational be notified at	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	If Yes, specify C		Rican, etc.)	Specify: WI	te, etc. HITE
ם ח	"natur	ieted	15. Decedent's Educ (Specify only highest grade	ation 16a completed)	Decedent's Usual Occ (Give kind of work doi	cupation ne during most of work ired)	ing 16	b. Kind of Business	/Industry
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2	be filectal Hyg	Bec	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		
7	hould I d Meni marke matic	ဥ	ALFRED KNAPP 19a, Informant's Name/Relationship (Type	A Print) 19h	D. Mailing Address (Stre		CE PRIM		Zin Code)
Z	alth an 27 is in traus		DAVID H. deVILL		42 WOODWA				21093.
inore,	Peges 1 a nent of Hea ant: if itam ury or othe		20a. Method of Disposition 1	moval from State cemete	of Disposition (Name of ary, crematory or other p DRIDGE	olace)	Date 20 1/2006	c. Location - City or PIKESVII	
baitimor	permit. Peges Depertment of important: if it any injury or o		21. Signature of Fungral Service License	a company	22. Name and Add HENRY W. 16924 YO	dress of Facility JENKINS ORK RD MO	& SONS NKTON, M	CO. 21111	l .
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	sit s	liner	Sequentially list conditions, in any, reading to information cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		-		
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90		edicai							
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	To tha Hospital or Attandi within 24 hours effer death. To the Funeral Diractor: A ∖completely filled in by the fu	edicai	29a. Certifier Certifying Phys (Check only one) Madical Examin	cian: To the best of my knowledger: On the basis of examination an and manner stated.	e, death occurred at the ad/or investigation, in m	time, date and place, y opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	cuis	29c. Lice	inse number	29d	Date signed (Mont	
	12		30. Name and address of person who could be seen to the seen and address of person who could be seen and the	npleted cause of death (Item 23a)	(Type, Print) D 6301	NCHALL	3 ST !	BALTIMOR	12006 GM21212
	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signature	South .				

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health and Mental Hygiene | 1 - State of Maryland / Department of Health And Mental Hygiene | 1 - State of Maryland / Department of Health And Mental Hygie 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month Year 05.28 JOSEPH EDWARD CALDWELL FAGGINS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RYICHIE BALTIMORE NIA HOSPICE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months 1**⊠**M 2□F 231.20.9856 80 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director BALTIMORE 1 No Yes 2 No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 863 REINHARDT STREET 21230 usa 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE ANTWERPEN NA 81H GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, MARIE FRANCIS JOSEDH FAGGINS BOOKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 83 CAMPFIELD ST. LINDA GRIFFIN-DUNK IRVINGTON NJ 20b. Place of Disposition (Name of MIDNAY, BAPTISTING CHURCH OL . 03.06 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE aughn 5151 BALTO, NATE PIKE, BALTO, MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Carcinoid syndrome, metastatinto ponenara his Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide

/Medical Examiner Box 68760 physicien 9 Records, P.O. the Division of Vital After t the Hospital or Attending death. after death within 24 hours a

Funeral

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Pages 1 and 2 should be fill ment of Health and Mental Htant: If item 27 Is marked off

permit. Page Department of Important: If eny injury or once.

Physician

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death

within 72 hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

State Registrar

filled in by the

29a Certifier (Check only one)

29b. Signature and title of certifier

BEKEDICT (50 W. LANYACE ST., BALLIM ME. O'YOBA') 2005 Registra's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 008583

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and M State of Maryland / Department of Death Certificate of Death		2000 1/200
3	4		Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
ę	Physicia /Medic	2	Lawrence E. Fontz, Jr.	May 29	, 2006 1-25A M
- 3	Examin	1	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	7	c. County of Dealh
	20 a L	200	5 Social Security Number 6 Sex 1) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	mule	Hung Arman
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 11-06-192	9. Birthplace (State or Foreign Country) MD
	MEGIO		Usual Residence of Decedent	11-00-192	.5 MD
rylanc	how		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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Mith t≑	be a	Dire	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Country?
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	alth a		Mr. Milton Fontz / brother 1113 NE 19th Terrace	Cape Cor	al. FL 33909
ore	of He				Location - City or Town, State
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Baltimore, permit. Pages 1 ar	Department of Important: If i any injury or once.		21. Signature of Puneral/Service Licenses 22. Name and Address of Facility Sing		
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Of Phys	rthis raldir	- To	The real results and results a	ne 5 Residence 28d. Describe how in	6 ☐Other (Specify)
On	th. : After	tlon	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury al Work? 1 North		a., 00001100
Division of Vital Records,	octor by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		and Number or Rural Route Number,
	s afte	Certification:	4 Homicide Soldmines building, etc. (Specify)	City or Town, Sta	ite)
Division of Vital Records, P.O. Box 68 To the Hospital or Attanding Physician: The law requires that the death certifical	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only (Ch	and due to the cause	(s) and manner as stated.
the	n 24 he F	Medi	one) and manner stated. 29b. Signature and title of certifier 29c. License number		
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Ĕ	with To t		WI NILEDIA	nr	Date signed (Manth, Day, Year)
Ĕ	Tot		MD 048006	05	ald signed (Manth, Day, Year)
Ţ			30. Name and address of person who completed cause of death (Item 23a) (Type, Print),	5/m	Burnil, mi)
70	Him 2 5		MD 048006	105 Glan	Burnie, mD

		For State Registrar	State of Maryla	•	artmen	t of Health and e of Death			6 17209
W 4		1. Decedent's Name (First, Middle, Last)				2. Date of Dear	th Day Yea	3. Time of Death
Physicia /Medic	173	MIRIAM EDYTH FAR	RWELL				May 28,		6:40 a M
Examin	280	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location of De	ath	4c. County of De	
		Montgomery Gener			O1n			Montgom	
Funeral Director		5/9-36-9/04	x 7. Age (In y	rs. last birthday, Yrs.	If Under Months			Year) 9. E 1915 I1	Birthplace (State or Foreign Country) linois
and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "netural", or Items 23s or 28s-f show aumatic event, the Medical Examinating Intelligial and	ō	Maryland Montgome:	rsz S	ilver S	nrina				1∭Yes 2 No
28a	Director	10e. Street and Number		TIVET B	10f. Zip	Code	1	0g. Citizen of What	Country?
3a o	0	3700 Internation	nal Drive		2	0906		U.S.A.	
ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	1	lent of Hispanic Origin? of Cuban, Mexican, Pu	(Specify Yes or No-		merican Indian,
or Ite	Ē	1 Never Married 2 ☐ Marned	1 ☐ Yes 2 X No			∑X No Specify:	orto ritoari, etc.)	Specific	
E	d by	3 Widowed 4 Divorced	Year or Dates:		10 103 2	проспу.		Зреспу.	Vhite
netu	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usua kind of wor	al Occupation ork done during most of v se retired)	vorking	16b. Kind of Busine	ss/Industry
L S	ldw	Elementary/Secondary (0-12)	College (1-4or 5+)			se retired)		77.1	
it in	ပိ	17. Father's Name (First, Middle, Last)	5+	Princ	ripar	18 Mother's N	lame (First, Middle, i	Educatio	n
0 p	Be		111					valuon oumano,	
nark	2	Ernest Chilton E		19h Mail	ing Address	(Street and Number or	Massman	City of Town State	Zin Code)
7 is r traur					3	a Lane, Spe			
item 27 other tr		Tony B. Moe - Fr		b. Place of Disp cemetery, cre				20c. Location - City	
ariant: If item 27 is marke njury or other traumatic i.		1 X Burial 2 ☐ Cremation 3 ☐ I	Hemovai irom State	cemetery, cre ort Linco			/1/2006	Brentwood	l, Maryland
Important: If its any njury or of once.		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Furgeral Service Lights				d Address of Facility			
any enc		1011/11/11	land			altimore Av			
		23a/Part1. Enter the disease, or comp	lications that caused the d						Approximate
5,		shock, or heart failure. List only o	one gause on each line.	110					Interval Between Onset and Death
ician dical		disease or condition resulting in death)	Due to (or as a con	+ ora	M V	1-ai hive			24 hours
niner			Due to (or as a con	A C C	7				18 hours
QC.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence of):					10/43/12
ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. 1)	incu	rd -	Truck			
rial-tr	Exa	resulting in death) Last	Due to (or as a con	sequence of):	2				
ysicia ne bui	cal		d						
attending physician and for use as the burial-transit	Physician/Medi	IF FEMALE:							
r use	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		⊒Ectopic pr	egnancy		23d. Date of a	delivery Day Year
id be detached fo	sici	1 ☐ Yes 2 🔀No	4☐Pregnant at time 9☐ Unknown	of death 5	Other (sp	ecify)		Month	Day 16a1
ətach	Phy	9 Unknown					00. 5:11.		
pe q	þ	Part II. Other significant conditions co	ontributing to death but not	resulting in the	underlying c	ause given in Part I.			to the cause of death?
pino	ted	Anemia.			_		-	es 2.5 % No 3.⊟	Probably 4 Unknown
rector, page 2 should	Completed						24a. Was a autops	v prior	autopsy findings available o completion of cause of
page	no Do						perform 1 ☐ Yes	med?_ death	? es 2□ No
director,	Be (25. Was case referred to medical examiner?					eath (Check only or	re)	
ral dire	မှ	1 ☐ Yes 2 ☑ No		2 ER/Outpatie			Home 5 ☐ Reside		pecify)
the funera	e e	27. Manner of Teath 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time (8c. Injury at Work?	28d. Describe h	ow injury occurred	
the f	cat	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 No	001 1 10		
0	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, s ecify)	treet, factory	/, office	28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
lled		200 Cartillor 17 Cartillor	rainiama Tarta kanan	len oud-d-	th. a.c.		1		
tely f	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my iner: On the basis of exame and manner stated.	nination and/or i	in occurred nvestigation	at the time, date and pla , in my opinion, death or	courred at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
completely filled in	Mec	29b. Signature and title of celturer	and manner stated.		290	c. License number	2	9d. Date/signed (Mo	onth, Day, Year)
. 8			711. 1		1/	31/0		5/20	1000
7		20 11	completed cause of death	SCIAN.	Print)	00100		100	100
10		Suam Parking	.00			Center Dri	ve Rooler	ille MTN	20850
Sta	ate	31. Date (Month, Day, Year)	32 Registrar's S	ignature 4	edical	Senter DIT	ve, MUCKV	TITE, EID	20030
Regist		JUN 0 1 20	06 BARRES	D A	E HELD				

			1 - For State Registrar		Department of Health ar Certificate of Death	Reg	- Z II II b	17210
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las	F. Glen	,	2. Date of Death Month May 2	Day Year 6,2006	3. Time of Death 3. 46 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of		4c. County of Death	timore
	uneral rector		5. Social Security Number 6. Se	711 00/2	thday) If Under 1 Year If Under 24 Yrs. Months Days Hours	Min. (Month, Day, Ye	9. Birth	place (State or Foreign intry)
Maryland	f show	or	Usual Residence of Decedent 10a. State 10b. County	A 10c. City, Town	n or Location,			10d. Inside City Limits 12 Yes 2 □ No
h with the I	st by notif	Funeral Director	10e. Street and Number	reliedere Ave.	18 10f. Zip Code 21215) 10g	. Citizen of What Cou	intry?
yicaling Z. I.Z. 100000 ould be filed within 72 hours after death with the Maryland Mental Hydiene.	important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White, Specify:	can Indian, , etc.
within 72 hou	than "natura se Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)		b. Kind of Business/Ir House K	eapine
should be filed v	rked other lic event, II	To Be Co	17. Father's Name (First, Middle, Last)	Reddicks	18. Mother	s Name (First, Middle, Mai	iden Sumame) E (VI)	
and 2 shou	n 27 Is mar ier traumat		19a. Informant's Name/Relationship (7)	-mother 26	Mailing Address (Street and Number 623 w. Belve de	re Ave 18 8	lado, mdi	21215
rmit. Pages 1	tant: If iten jury or oth		20a. Method of Disposition 1	nemoval nom state	Disposition (Name of ry, crematory or other place) Curmer Com L	-3-06 B	c. Location - City or T	own, State
permit.	any in		21. Signature of Euneral Pervice Line		22. Name and Address of Facility	270 Fred Hom	ETON Par	nd.21279
			shock, of heart failure. List only of	dications that caused the death. Do rone cause on each line.	not enter the mode of dying, such as ca			Approximate Interval Between
	sician edical		Immediate Cause (Final disease or condition resulting in death)	a AIDS	-0			Onset and Death CGL
	miner			b. H I V	or):			Years
D.	sit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):			
e be execute	sician and s burial-transit	Ω	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):			
he death certificat	been signed by the attending physician a should be detached for use as the burral.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
requires that	an signed by uld be deta	þ	Part II. Other significant conditions co	ontributing to death but not resulting in	n the underlying cause given in Part I.		co use contribute to t	the cause of death?
The law re	page 2 sho	Completed				24a. Was an autopsy performed 1 □ Yes 2	prior to co	opsy findings available ompletion of cause of
cian:	certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Oth	f Death (Check only one) ing Home 5 \(\square\) Residence		14.0.00
> 0	r: After this e funeral d	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T	tipatient 3 DOA 4 Nurs Time of njury M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how		y) 7703 PTCE
anding Physic		Ę	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
tal or Attending Physic	al Directo ed in by th	Certi				place, and due to the same		
Hospital or Attending Physic A hours after death	e Funeral Directo letely filled in by th		29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my knowledge iner: On the basis of examination and and manner stated.	e, death occurred at the time, date and dor investigation, in my opinion, death	occurred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certi	(Check only 2 Medical Exam	iner: On the basis of examination and	d/or investigation, in my opinion, death	occurred at the time, date	and place, and due to Date signed (Month,	o the cause(s) Dav. Year)

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

JUN 0 1 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year GRAHNAM TOANNE 2006 14:32 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMER E.R. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 K F Yrs. Director 578-78-0678 OCTOBER 4 1954 WASHINGTON, DO Usual Residence of Decedent with the Maryland 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow or iteme 23a or 28e-f ehov Tiner must be notified at 1XYes 2 □ No Director PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20706 9129 MCHENRY LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ā No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by Specify 3 ☐ Widowed 4 ☐ Divorced "natural" event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMIN 12th PRIVATE other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental JOHN W. GRAHAM REBECCA 2 CONWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i JAMES E. GILBERT/FRIEND 9129 MCHENRY LANE LANHAM, MARYLAND 20706 20b. Place of Disposition (Name of centerry, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of P important: If ite eny injury or of pnce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) RESURRECTION CEMETERY 6/1/2006 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myocardial Infarction Priysician Acuk disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien of for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea N 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à sign 1 be 0 Mellitus eted 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Obesity d 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check only one S Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 265 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Medical Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide To the Funerel Dir Fo the Hospitei 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Z_ | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May, 24,2006 who completed suse of death (Item 23a) (Type, Print) auss M.D. 8600 OLD GEORGETOWN Road BETHESDA, MARYLAND 20814 31. Date filed (M 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2°06 **Physician** 14.28 M Mary Elizabeth Grant MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore N/A It Under 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 🗙 🔀 F Yrs 220-40-8913 64 1941 Director Maryland Usual Residence of Decedent within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Yes 2 □ No Baltimore Maryland N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA 818 W. 32nd Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2201No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo ģ Specify: white 3X Vidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 6 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy, Important: If Itsm 27 is marked oths any injury or other traument 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn O'Brien Edward O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8574 Neptune Drive Pasadena, Maryland Raymond J. Baublitz Son 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Vernon U. M. Church Cem. 6/2/06 White Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Part. Enter the diss st. or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Kespinaion **Physician** /Medical resulting in death) Due to (or ana consequence of Examiner neumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Melastatic Caranoma-lung the ettending physician and hed for use as the burial-transit The law requires that the death certificate be executed SPA resulting in death) Last Due to (o a a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. It yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time ot death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ esebro Vascular 1X Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an hes autopsy performed? this certificate 2. No 1 ☐ Yes 2 No. 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 No ٩ 1 MInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Tes 2 No death. investigation М 2 Accident filled in by the Director 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) within 2 To the 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital KISHORE SHARMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10f317 perFH 0856 6/1/2006 TT Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year GOLDIN ZENADIY 28 : 55A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTI MOR SINAI HOSPITAL OF BALTIMONE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 05/01/1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 DEL ADLIC **Funeral** 1 M 2 □ F 217-45-7220 Director 80 Yrs BELARUS GOLDIN, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD N/A BALTIMORE 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Iteme 23e 2095 ROCKROSE AVENUE **BELARUS** 21211 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 No WHITE Specify: Specify: 3 NWidowed 4 Divorced "natural". YND WW 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) MAINTENANCE MECHANIC AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental and Mental GOLDIN GENYA PODLIPSKY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2: ment of Health a tant: If item 27 is VICTORIA MARMALKOV / GRANDDAUGHTER 3441 EASTERN ROAD - FINKSBURG, MD 21048 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. BALTIMORE HEBREW CEM. 05/30/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finaf disease or condition resulting in death) **Physician** Sepsis اعتيان /Medical Due to (or h a consequence of): Examiner Meumoni Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cerebrovescular sician and Due to (or as a consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year the a 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 1 Tyes or Attending Physician: Be 25. Was case referred to medicaf examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director; After this od in by the funeral d 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2006

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31. Date filed (Month,

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32. Registrar's Signature

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SINAI HOSPITAL OF BALTIMORE

May 28

2401 W BELVEDERE AVE, BACTIMORE MD

2006

Amend item#18,19b,perfff,0856,6/1/2006 The State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY 29 Day 2006 ear RUTH GOMES 6:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 219-10-1504 79 Director Yre 10/06/1926 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural" ~~**
eny fillury or other traumatic ever. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director BALTIMORE 1 ☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 Tes 2 No WHITE Specify: 3 ☐ Widowed 4 v Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shipley **MEYER** LERNER HELEN 2 ROSENBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6400 BALTIMORE NATIONAL PIKE—CATONVILLE, MD 21228 19a. Informant's Name/Relationship (Type, Print) MARTIN ROSENBERG / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 05/31/2006 BALTIMORE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RCING /Medical Due to (or as a consequence of): Examiner 3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed use as the burial-transit has been signed by the attending physician and ge 2 should be detached for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hosoital: 2 1 Yes 2XNo Other: 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ë. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (ttem 23a) (Type, Print) 31. Date filed (Month, Day) 32. Registrar's Signature State

Registrar

			1 - For State Registrar	State of Maryland	d / Depa	artment o	of He	ealth and l		giene	006	17215
			Decedent's Name (First, Middle, Last,)					2. Date of De			3. Time of Death
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	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, To	wn, or	Location of Death		- 10	ty of Death	
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	nit. Portani prtani injury		4 □Donation 5 □ Other (Specify) 21. Signal tree of Funeral Service License			. Name and A		UNO 5/31				RE, MD
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	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 ✓ Certifying Phys (Check only 2 ☐ Medical Examin	sicien: To the best of my knowner: On the basis of examination	rledge, death	occurred at the	he time	, date and place,	and due to the	cause(s) and m	anner as st	ated.
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	5 W T 70		29b. Signature and title of certifier	Un Kin		29c. Li	cense r	VQ 1	-	29d. Date signe		. ,
7			1111 10	(N MAN)		D	45	101		MY	20,	2006
Ì	0		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)	RT	ROAD	ZANDAU	STAMA	MARI	2006 (LAND Z1133
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	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Betty Lee Hoehn 4a. Fadlity Name (If not institution, give street and number)		4b. City, Town, or Location of D		Day Year 26, 2006 4c. County of Death	3. Time of Death 10:40 A M			
	Funeral Director	- 1	Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. In $2 \times 12 - 26 - 1032$	last birthday) Yrs.	Timonium If Under 1 Year ff Under 24 Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Y. July 28,	Baltimor 9. Birth 1928 Mar	place (State or Foreign Intry) LYLAND			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importment of Health and Anothe Hygiene. Importment: If Item 23 or 28e-1 ehow any injury or other traumatic event, Ite Marylan Examinar must be notified at once.	ctor	Usuaf Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 Tyes 2 No.								
		Funeral Director	10e. Street and Number 8816 Dearborn Drive 11. Maritaf Status 12. Was Decedent Ever in U.	6 12 4	10f. Zip Code 2123	6	g. Citizen of What Country? U.S.A.				
9003			1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	Vas Decedent of Hispanic Origin' Yes, specify Cuban, Mexican, Pi	(Specify Yes of No- Jerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
Baltimore, Maryland 21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	working 161	16b. Kind of Business/Industry Own Home						
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ore, Ma			Steven Hoehn (Son) 20a. Method of Disposition 1 [VBurial 2 Commation 3 [Removal from State]	1824 ace of Dispos emetery, crem	Hanford Road, I	Baltimore, N	MD 21237 c. Location - City or T	own, State			
Baltim			Gardens of Faith Cem. 5/30/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236								
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1		Σ	29b. Signature and title of certifier		29c. License number D43725		Date signed (Month,)				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar 31. Date filed (Martin Cay Year) 2006 32. Registrar's Signature										

MAY 26, 2006 10:40 a.m.

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			For State Registrar		State of M	aryland		artmen rtificate			Mental Hy	ygiene .Rog. No.	Z U U b	1721
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Balt	permit. Pages 1 Department of H Important: If its any injury or ott		21. Signature of	unerat Service Lio	Mancer					ss of Facility S .59 North	-		1ens 71639	
	Physician /Medical Examiner		shock, or he tmmediate Cause disease or conditi resulting in death	eat failure. List on: (Finat ion)	mplications that caused y one cause on each line. a	NON!	A	ter the mod	e of dyir	ig, such as cardiae	c or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	n certificate be executed and and use as the burial-transit	edical Examiner	Sequentially list of any, leading to cause. Enter Unic Cause (Disease of that initiated even resulting in death)	dertying or injury ts	c Due to (or as									
O. Box	ne death certif the attending thed for use a:	Physician/Med	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	□Ectopic pr □ Other (sp		,		2	23d. Date of del Month	ivery Day Year
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Records,	w requir been si should	fed	DEME								1	Yes 2	□No 3□Pr	obably 4 Dunknown
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on of	ding h. After fune		27. Manner of Dea 1 Natural 2 Accident	ath 5 Pending investigat	28a. Date of Inju (Month, Da	iry y Year)	28b. Time o Injury	of 2	8c. Injur Wor	y at	28d. Describe			
Division	tal or Attending s after death. et Director: Afte	Certification:	3 Suicide 4 Homicide	6 Could not	be an Place of In	jury · At ho ic. (Specify	me, farm, st	reet, factory				(Street and own, State)		iral Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical (29a. Certifier (Check only one)		Physician: To the best aminer: On the basis of and manner st	f examinat								
	To the within 2 To the comple	Me	29b. Signature an	d title of certifier				290	. Licens	e number		29d. Date	e signed (Monti	h, Day, Year)

State Registrar

SURESH VORCHESE

31. Date filed (Month, Day, Year)
JUN 0 1 2005

DHMH 17 Rev 1/2001

LIVING-STON

32 Registrar's Signature

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30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

SUITE # 101, FORT WASHINGTON, MD

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BARBARA ANN HALL 2:05 PM 2006 Mary 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore city (tospital enter If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NY Social Security Number 8. Date of Birth (Month, Day, Aug 18, 6. Sex **Funeral** Days Min. Months Hours 1 M 2 X F 62 Yrs. 124-34-1456 Aug Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Baltimore Co. Reisterstown Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Leyton Rd. USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. fited within 72 hours after Hygiene. 1 ☐ Yes 2 X No tf Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 🏿 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe any injury or other treumatic event, 90028. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Graff Ann Debello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Hall 300 Leyton Rd, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Farmingdale, NY St. Charles Cemetery 6/01/06 21. Signature of Feneral Service Lice 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeal Home Reisterstown, md 21136 23a. Part 1. Ente he diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure tmmediate Cause (Final Sepsis Physician Days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner cause (Disease or injury The law requires that the death certificate be executed as the burial-transit ongethe that initiated events resulting in death) Last С Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ allane 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 □ No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₹ No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number PI8437BPQA May 27, 2006 7 Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahallati, 3001 South Hanover Street, Baltimore, MD Ahmad 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ERNARD 201 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Ellicott City Health & Rehab Center Ellicott City
If Under 1 Year | If Under 24 Hrs. | 8, Date of Howard

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex 104 M 2□F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Yrs. 218-18-1281 83 Usual Residence of Decedent August 30, 1922 Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 5797 Railroad Ave 21075 U.S.A. 12. Was Decedent Ever in U.S. Amfed Forces?

1 kg/yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No 1943 Specify: 3 Widowed 4 Divorced Specify: natural 1946 Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement unk Carpenter 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) LUKNOWA 2 mondan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If itam 27 Ia any injury or othar trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore, Maryland 21244

Date 20c. Location - City or Town, State Ms. Alberta Colbert Neice 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Voterans Cemeter Maryland Voterans Cemeter Sarrison Forest 06/05/2006 Garrison Forest, Maryland Slack Funeral Home, P.A.

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Slack Funeral Home Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attanding Phyaician: The law requires that the death certificate be executed TROUT that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Lleknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dale of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertilier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 AR 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 1 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Frank Ray Innoc		State 1- For State	of Maryla		rtment of tificate of		nd Ment	al Hygie	ene	2	006 1722
Physicia	an/	Registrar 1. Decedent's Name (First, Middle, La	ist)		uncate of	Dealli		12 D	Reate of Deat	eg. No.	The same of the same of
Medical Exami		Frank Ray Innoce	enti. Ir					N	lonth ay 20, 2	Day Yea	3. Time of Death 0528 hrs
-		4a. Facility Name (if not institution, g				b. City, Town, o	r Location of		ay 20, 2	4c. County of	
		Doctors Community Hosp	oital		i	Lanham				Prince G	
Funeral		Social Security Number 6. 8	Sex 7	7. Age (In yrs. la	st birthday)	If Under 1 Yea	ar If Under	24Hrs. 8.	Date of Birt	th (MM/DD/YYYY	•
Director		217 70 4905 1	M 2 F	47	Yrs	Months Day	s Hours	14.	2/06/		Foreign Washington.
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amy		10a. State 10b. County		10c City,	Town or Locati	on					10d. Inside City Limits
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21, ould b d Men s mar	ဥ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stree	et and Numb	er or Rural I	Route Num	ber, City or Town	, State, Zip Code)
MD nd 2 sho alth and m 27 is anmati		Anthony Ray Inno	centi -	Brother	T .						ia 22511
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. P	lace of Disposi	tion (Name of ce	metery,	Date			City or Town, State
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ultir nit F artme oortan	1	4 Donation 5 Other Specify 21. Signature of Funeral Section 10	/ / / / / / / / / / / / / / / / / / /	1100	22. N	ame and Address	of Facility	Gasch	2000 F	naral	ome, P.A.
in in per B		Mult 1	Thu								MD 20781
Physician	7	23a. Part I. Enter the disease, or com	olication at cau	sed the death.	Do not enter th	e mode of dying,	such as car	diac or resp	ratory arre	st. shock or hear	t Approximate Interval
/Medical		failure. List only one cause on e	ach n .						,	,,	Between Onset and Death
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Box 68760, e death certificate be the attending physicied for use as the buri		IF FEMALE: 3b. Was decedent pregnant in the	1 Live birt	tcome of pregna h		al death 3	Ectopic p	regnancy		23d Date of d	
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O. hat th	by P	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the ur	derlying cause g	iven in Part	1. 2	3e. Did tob	acco use contribu	ute to the cause of death?
D, P									1 Yes	2 No 3	Probably 4 🗸 Unknown
Division of Vital Records, P.O. Box rad or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the att red in by the funeral director, page 2 should be detached for	Completed							2	4a. Was ar		ere autopsy findings available
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the H nin 24 the F	100	29a. Certifier 1	:On the basis of a	r my knowledge examination and	, death occurre I/or investigation	d at the time, da n, in my opinion.	te and place death occui	e, and due to rred at the ti	the cause(me_date_ar	s) and manner as	s started.
To the within To the comple	e l	29b. Signature and title of certifier	and manner stat	ed		29c. License					
	-1	higher, mit	,			O.C.N					(Month, Day, Year)
	L					0.0.1	/I. L.			May 21, 2006 —	D
	- [30. Name and address of person who Ling Li, MD Assistant M	completed cause of edical Exami			Baltimore, I	MD 24204	1			
	7		-			Daitimore, I	VID 2 [20]				
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		4	For State Registrar	State of Maryland	Dep	artment o	of Health a		Reg. No.	2006	17221
×	Physicia /Medic Examin	al -	I. Decedent's Name (First, Middle, Last) LETOY R Ja. Facility Name (If not institution, give s	Jones (reet and number)		4b. City, Tow	m, or Location o	2. Date of Month	Day 27	Year 2006 County of Death	3. Time of Death
	Funeral Director	٠.	Franklin Square 5. Social Security Number 6. Sex 120-20-0265	HOSPItal 7. Age (In yrs. last 76	birthday) Yrs.	If Under 1 Y	ear If Under ays Hours		Birth	9. Birthe ag Mar	lace (State or Foreign
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	eath with fhe M ns 23a or 28a-f must be notifie	by Funeral Director	10e. Street and Number 5 Timber Creek 11. Marital Status	Ct. 2. Was Decedent Ever in U.S.	13.	10f. Zip Co	21	gin? (Specify Yes or	USA	zen of What Cour	
5-0036	72 hours after death with the Maryland natural; or Items 23s or 28s-f show dical Examiner must be notified at	d by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No ff Yes, Give Year or Dates:		If Yes, specify		gin? (Specify Yes or i, Puerto Rican, etc.)		Black, White,	etc.
21215-0	- E	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual O kind of work d DO NOT use re	ccupation lone during mos etired)	t of working	Sto.	nd of Business/In	dustry
Maryland	should be filed nd Menfal Hygis marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) John P. Jones 10. Informatio Name (Relationship (Tur	no Reigh	ioh Maili	ng Addross /St	ma	er's Name (First, Mid + tie Jor er or Rural Route Nu	185		a Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with fihe Maryla Department of Health and Menfal Hygiens. Important: if item 27 is marked other then "natural, or items 23a or 28a-1 show any injury or other traumatic event. Its Medical Examiner must be notified at any injury or other traumatic event. Its Medical Examiner must be notified at any injury or other traumatic.		19a. Informant's Name/Relationship (Type) Defores Cox - da 20a. Method of Disposition 1 Burial 2 DCremation 3 - Re	ughter 20b. Plac	520 e of Disp etery, cre	5 Goo	dnow i	RdA E	20c. L	mb a	2/206 own, State
Baltimore,	permit. Pag Department Important: I any injury c		4 Donation 5 Other (Specify) 21. Signatur of uneral Service License	King		2. Name and A	ddress of Facili	7-3-06 H 240 Fra	£ 4	dallstou o Pass Ba	10, 1710 Ho MO 2/23!
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8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	ice of,						
O. Box 6	ne death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\end{ye} \) Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat	ath 3	⊒Ectopic pregn ⊒ Other (specif			_	23d. Date of delive Month	ery Day Year
rds, P.O.	v requires that the de been signed by the should be detached	þ	Part If. Other significent conditions con	tributing to death but not resulting	ng in the i	underlying caus	e given in Part I			se contribute to the	he cause of death?
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Division of Vital Records,	Attanding Physician: The law requires that the death certificate be executed rideeth. sctor: Atter this certificate has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-fransit.	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Yeer)	VOutpatie Bb. Time of Infury	of 28c.	Other: 4 Nu Injury at Work? 1 Yes 2	No	esidence (be how infun	y occurred	
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	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	Medica		ner: On the basis of examination and manner stated.		nvestigation, in	my opinion, dea	ith occurred at the tir	ne, date and	place, and due to	o the cause(s) Day, Year)
F			30. Name and address of parson who co DR Kelly Miller	mpleted cause of death (Item 2: 9000 Franklin			ve Ba	18 Itimore	Mary	Mand .	21237
	St Regist	ate rar	31. Date filed (<i>Month, Day, Year</i>) JUN 0 1 200	32. Registrar's Signatur	e A	medi					

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State of Maryland / Department of Health and Mental Hygiene ?

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/Medi Examii	cal	Donald Edwa 4a. Facility Name (If not institution, gi Saint Joseph		Cent	er	4b. City, Town, o	r Location of	Death WSON		4c. Cour		imore
Funeral Director			Sex 7. Age		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth (Month, Day, Vember 2.	3,1922	9. Birthp Cour Mary	elace (State or Foreign Nand
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Iteme 23e or 28e-f ehow other traumatic event, the Medical Exercities maint be notified as	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim 10e. Street and Number	ore		Town or Lo				11	Og. Citizen o	of What Cour	0d. Inside City Limits 1 ☐ Yes → No
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hours after deal	by Funeral Director	11. Marital Status 1 □ Never Married 2 ※ Varried 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? XXYes 2 N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XX No	lispanic Origir an, Mexican, I Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)		ace - Americ lack, White, cify:	
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id 2 sho Ith and I 27 Io m		19a. Informant's Name/Relationship Sondra Gail Kelly		ife		ng Address <i>(Str</i> eet lindwood						Code) 212
of Hea		20a. Method of Disposition 1 XXurial 2 Cremation 3 [Removal from State	Cei	metery, crer	sition (Name of natory or other place		Date			n - City or To	
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i Diffe	Certification:	3 Suicide 6 Could not 4 Homicide determined		ury - At hon c. (Specify)	ne, farm, str	eet, factory, office		281	Location (Str City or Town		nber or Rura	l Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination	rledge, deatl on and/or in	n occurred at the tirvestigation, in my o	ne, date and popinion, death	place, and occurred	due to the ca at the time, da	use(s) and rate and place	manner as st	ated. the cause(s)
To the within To the compl	Ž	29b. Signalure and title of certifier	~	a		29c. Licens	e number Ø263		25		ned (Month,	
Ó		30. Name and address of person who FRANCIS KHOO.				Print) DRIVE T	OWSON	MAR	YLAND	2120	14	
St Regist	ate '	31. Date filed (Month, Day, Year) JUN 0 1	32. Registra	ar's Signalı	Jre	horse						
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			For State Registrar	State of I	Maryland / De	epartment of Certificate o			giene Reg. No.2 0 0 6	17224
	Physici	an	1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea	ath Day Year	3. Time of Death
	/Medic	_	Marion Frances		- 1			5-29-	2006	06:40P M
	Examin	er	4a. Fecility Name (If not institution Genesis Elder (. 3		Brook1	, or Location of D	eath	4c. County of Death	
	Funeral		5. Social Security Number		Age (In yrs. last birth	fay) If Under 1 Yea	ar If Under 24 i			place (State or Foreign intry)
X	Director		212-26-0154	1 ☐ M 2 🔀 F	87 Yr	s. Months Day	s Hours N	4-8-19	y, Year) Cou 19 MI	
	pur *		Usual Residence of Decedent 10a, State 10b, County	,	10c. City, Town o	or Location				10d. Inside City Limits
	Maryii f eho	ō		Arundel		n Burnie				1 ☐ Yes 2 ☑ No
	28a-	Funeral Director	10e. Street and Number		010	10f. Zip Code)		10g. Citizen of What Cou	intry?
	h with	ai D	299 Scotts Mai	nor Drive		2106	1		U.S.A.	
	ems :	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13. Was Decedent o	f Hispanic Origin?	(Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent. It's Madical Examinat must be notilled at	by Ft	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Yes Give	No No	1 ☐ Yes 2 ☑ N				nite
9	hour	edb		nt's Education		ecedent's Usual Occ	upation		16b. Kind of Business/li	ndustry
215	hin 72 nn "ng Medir	plet	(Specify only higher Elementary/Secondary (0-12)	ost grade completed) Cotlege (1-4c	(0)	Give kind of work dor fe. DO NOT use reti	ne during most of	working		,
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n	be file	Be	17. Father's Name (First, Middle,					Name (First, Middle,		
Maryland 21215-0036	should be and Mental marked o umatic eve	2	Edward Theodore			Inilian Address /Ctra		Emily Co	ckey er, City or Town, State, Zi	a Codel
a ≥	and 2 sho ealth and n 27 is m		Mrs. Marion Fra		•				le, MD 21108	
ē,	~ 4 2 5	1	20a. M of Disposition		20b. Place of D	isposition (Name of crematory or other p	-	Date	20c. Location - City or T	
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alti	permit. Departm Importa eny inju		21. Signature of Ameral Service	Licensee	20			-	Funeral Hon	-
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			23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one cause on each	h line.					Approximate Interval Between Onset and Death
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Вох 6	eath certifica attending ph I for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnancy				23d. Date of deliv	en/
ă	that the death cer ed by the attendin detached for use	iciar	in the past 12 months?	4 Pregnant	n 2 ☐ Fetal death t at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		Month	Day Year
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ioi	endin sath. or: Aft	atio	Z [Accident	igation	Day reary mig		Yes 2 No			
Ξ	or Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place of	Injury - At home, farm, etc. (Specify)	, street, factory, offic	ө	28f. Location (S City or Tow	Street and Number or Rur m, State)	al Route Number,
	pital ours a oral C	Ce	29a. Certifier **Certifyi	na Physician: To the he	act of my knowledge .	looth assured at the	time data and al	and due to the	cause(s) and manner as	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical one)	Examiner: On the basis and manner	s of examination and/o	or investigation, in my	opinion, death o	ccurred at the time, o	date and place, and due t	o the cause(s)
	To this within To this compl	Me	29b. Signature and title of certific	er 1		29c. Lice	nse number		29d. Date signed (Month,	Day, Year)
			1/2-1'w	Jallons		D	31136		MAY 31. 2	2006
	10		30. Name and address of person	who completed cause of	of death (Item 23a) (Ty	rpe, Print)	00.00	0.00		
	10		BRIAN C. 31. Date filed (Month, Day, Year	WALLACE	m) 401	s KIC	DICIVE	140A1), 15A	ACTIMORES	m) 21236
	Sta Registr			006 See	istrar's Symature	rele			MAY81, 2 HCTIMORCT	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amendi item#19a, perInf. (2856.6/5/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** KINNE Month Year CACHERINE 6,27 AM 2000 /Medical 4b. City, Town, or Location C.—

RANDPZLSTTV N

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

9-2-1932 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSBKXL BALTIMORE NOMHWEG 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 578-46-6557 Yrs. Director 73 N.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes No Balto Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9500 Lyonswood Drive 21117 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Black Specify: ۵ 3 Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within nent of Health and Menta Hygiene. ant: if Item 27 is marked other then 'ury or other traumatic event, the Me Baltimore City College (1-4or 5+) 4 years Elementary/Secondary (0-12) Registered Nurse 12th grade Health Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Wilson Mary Lyles 19a Informant's Name/Relationship (Type, Print) Judith Kinney-Gladden Judith Kinney –Daugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other training. -Daughter 9500 Lyonswood Drive Owings Mills, Md 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Pk 6-2-2006 Arbutus, Md tural Service Licensee March F/H West 21. Sign 22. Name and Address of Facility 4300 Wabash Avenue Balto, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. bornot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** CLERTIC ADDINASCULAR /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death cartificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by tha a o 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Driknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an paga 2 s has autopsy performed? Yes 201No of Vital 1 Yes lo the Hospital or Attending Physician: after death.

Director: Aftar this certific
J in by the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Within 24 hours To the Funeral 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, that and plane, and the built buttle cause(s) and manner as stated. mplataly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 0 1 2006

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06-03337 Scott M. Luty

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		- For State legistrar					Certific	ate of i	Death				F	Reg. No.	Ĺ.,	. 01	10	116
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Funeral		5. Social Security N	umber	6. Sex		7. Age (In	yrs. last bir	hday)	If Under		If Under	_	8. Date of B					
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auò			10b. County			10c	City, Town	or Locatio	n							$\neg \neg$	10d. Inside	City Limits
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Aaryland 28a-f show 1 at once,	흱	10e. Street and Nun		1 3011			Onara		10f. Zip C	ode				10a Citiz	en of Wha	at Count	rv?	
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Baltimore, permit Pages I ar Department of Hee important: If ite	- 1	1 Burial 2 4 Donation 5			Removalii	om State	Lacoc			ry S	vc.	5/23	/06	Roc	hest	er,	PA	
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	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith Day	Year	3. Time of Deat	th
	Physici /Medio		John Joseph La					May 29	2006		8:00 F	. М
	Examin	er	4a. Facility Name (If not institution, give				or Location of De	ath	4c. County			
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	eep .	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Raci Blac	e - Americ k, White,	can Indian, etc.	
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21215-0036	within 72 hours after deeth with the Maryland ene. then "neturel", or items 23a or 28a-f ehow the Medical Examiner must be motified at	q pe	15. Decedent's Edi	Year or Dates:		dent's Usual Occ	unation		16b. Kind of Bu			
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d)	of Health of Hea		Mary Lauer / W 20a. Method of Disposition	ife				ad, Pasa	adena, 20c. Location -			
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1760,	/Medical Examiner // Medical Examiner // Medical Examiner // Provided the private of the private	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I may lead in the immediate occurse. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of):		(6)		and	~	Onset and Death	<u></u>
.O. Box 68	es that the death certificat igned by the attending phy be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1	Fetel death 3	⊒Ectopic pregnan □ Other (specify)	псу		23d. Dat Mor	e of delive	ery Day Year	
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	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) TS Cartifying Phyone) 2 Madical Example 1	ysician: To the best o inar: On the basis of and manner stat	examination and/or is	th occurred at the nvestigation, in my	time, date and play opinion, death or	ice, and due to the courred at the time, d	ause(s) and ma date and place, a	nner as s and due to	tated. the cause(s)	
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	411		30. Name and address of person who o	empleted cause of de	eath (Item 23a) (Type	, Print) Z	D5 #	ospite	109	5	wp.)
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DHMH 17 Rev 1/2001

LAUER, John 5-292C

06-03495

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Paul Douglas Law State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Douglas Law Paul 0901 hrs Medical Examiner May 23, 2006 4a Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death NA Good Samaritan Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min Director 09-12-1959 213-76-5424 46 1 X M 2 Country) W. Va. Usual Residence of Decedent III y Oc. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No items 23a or 28a-f show NA Baltimore Md. notified at once. death with the Maryland Director 10e. Street and Number 10f Zip Code 10g Citizen of What Country? Apt. 21234 2430 Bridgehampton Dr. 21234 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, must be Armed Forces? White, etc. Never Married 2 Married X Yes 0 Yes 2X No specify hours after Widowed 4 X Divorced Yes, Give Year Black h and Mental Hygiene 27 is marked other than "natural", umatic event, the Medical Examiner \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed within 72 Baltimore, MD 21215-0036 We Teach & Tutor Teaching Asst. Yrs. 12th grade 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Ross Clyde Gwendolyn Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Apt. C, Balto., Sister 2430 Bridgehampton Dr., Julia Dorsey of Health a 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Pages 1 or other 1 XBurial 2 Cremation 3 Removal from State 6-1-06 Crownsville, Md. Crownsville Vet. ment o Donation 5 Other Specify Signature of Funeral Service L 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. F. H. East March see the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Part I Enter the disease, dr complications that of **Physician** failure List only one cause on each line Between Onset and /Medical Death End-stage renal disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, iner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and ian/Medical AMENDED item#23a,27,perME,g857,7/6/06 TT X UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE ending physuse as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months' Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No Yes 2 No 1 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be Hospital: 1 Other₄ Inpatient 2 CER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: (Month, Day, Year) 1 X Natural 1 Yes 2 5 Pending hours after death Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Funeral Homicide 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 one) and manner stated 29b. Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) O.C.M.E May 24, 2006 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore King MD strar's Signatur State 2006 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item, 29d, periodog 12856, 651506, 14th and Mental Hygiene of the Copies Are Legible.

Amend item 29d per doc 1856 6-1-06 with and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Karoly Viktor Levay g 00:8 May 17, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City 4813 Ellicott Woods Lane Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1□**X**1 2□ F 89 Director 592.51.8820 December 23, 1916 Hungary Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itema 23a or 28a-f show It a Medical Exaction round be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21043 U.S.A. 4813 Ellicott Woods Lane death v Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 □ 炊 olf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Medicine Elementary/Secondary (0-12) College (1-4or 5+) Physician 5+ other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth Be Peter Levay Maria Szakaly 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4813 Ellicott Woods Lane Ellicott City, Maryland 21043 Ms. Catalina Levay Daughter item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State to tuent 1 Burial 2 Semation 3 Removal from State = 5 permit. Page Department of Important: If any injury or once. 05/19/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD **Bayyiew Crematory** 21. Sign tu of Funeral Service Licensee 22 Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Hunkulla MO0535 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition euro endo Crine 10 months **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 8 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown plnods been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home scidence 6 Other (Specify) 1 Yes 2 No 2 this 28d. Déscribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After **+**□Natural 5 Pending investigation М 1 Tyes 2 No death. after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide within 24 hours a To the Funeref D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature apd title of certifier 29c. License number D41139 May 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knight, Clement MD 11055 Little Patuxent Pkwy. Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 2006 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Wright 0349 Lloyd 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Baltimore (enta tf Under 1 Year tf Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1√3M 2□ F Months Hours Director 185-42-8316 April 15, 1951 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic avant, the Medical Exertities in an investigation 1 ☐ Yes 2 🗓 No Director Lackawanna PA Carbondale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18407 USA Funeral 135 Wyoming St 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2(No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. ? is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Fabricator Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ment of Health and Menta tent: If item 27 is marked Eleanor VanVorst Wright J. Lloyd Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lloyd 135 Wyoming St., Carbondale, PA 18407 Wife othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or once. Our Mother of Sorrows Cem June 3, 2006 Greenfield Twp., PA 21. Sign wary of Funeral Service Licens is 22_Name and Address of Facility Fink Funeral Home, P.A. Gregory Fink ĸ. M01148 426 Crain Hwy S, Glen Burnie, MD 21061 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death r heart failure one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** otic Shock /Medical **Examiner** Idiopothic Dile
Due to (or as a consequence of): Dilated Cardianyapathy Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attanding Physician: The law requires that the death cardificate be exacuted burial-transit the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 200 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther: Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 🗷 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funaraf D 29a. Certifier 1🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P19836 May 31 2006 and address of person who completed cause of death (Item 23a) (Type, Print) 10 Street, Baltimore, MD South Greene James 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 05 LOSEPH JOHN 0325AM 26 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner R Adams Cowley Shock Trauma Ctr Baltimore Year If Under 24 Hrs. If Under 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 216-14-4073 Maryland 12/05/1922 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show If itam 27 is marked other then "natural", or iteme 23a or 28e-f ehos or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 Valen Court 21157 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "natural", or item any injury or other traumatic event, the Mentals 2000. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Peter Maika Pauline Skwirut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Valen Court Westminster, Maryland 21157 Ann M. Majka - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Holy Rosary Cemetery 22. Name and Address of Facility 05/31/2006 Baltimore, Maryland 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest.

Approximate Cause (Final) Onset and Death CEMIFICATION APPROVED BY MEDICAL ZUMMITES Immediate Cause (Final disease or condition resulting in death) Hemorrhage -ntoacranial Physician /Medical Due to (or as a consequence of): **Examiner** -all Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ pe icate has been sig , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certifical funeral director, r or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 □Natural 5 Pending within 24 hours efter death. To the Funerel Director: A 1 Yes 2 No 2 Accident investigation LOWN Stairs 22/06 Unknown 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide Residence 1101 Valen Westmister Loud To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1+8

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

James M



RAdams

ess of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Shock Trainia Ctr.

			Amend Item 28d per ME, G856, 06/0	ndelible Ink. Ensure All Copies 8/06dhb partment of Health and Mental Hy	Are Legible.
		•	1- For Amend Items 25,28d-r per ME, GR. Registrar	ertificate of Death	Reg. No. 2006 1/232
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Tohn McNamara	2. Date of Di Month A P I L	eath Day Year 3. Time of Death 801 A M
	Examir		4a. Facility Name (If not institution, give street and number) Northwest Hospital	4b. Cily, Town, or Location of Death	Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 12 F 8 O Yrs.	I Milledge 4 Vogs Milledge 24 Hrs. a = 1 + 1	
			Usual Residence of Decedent 10a. State 10b. County 10c. 6th. Town of I		10d. Inside City Limits
	the Marylan r 28a-f show notified at	ctor		erstown	1 Yes 2 No
	th with the 23a or 2	Funeral Director	100 Street and Number 1010 Kings bury Rd.	10f. Zip Code 21136	10g. Citizen of What Country?
9	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jesal Eva. utter nust be notified at			. Was Decedent of Hispanic Origin? (Specify Yes or Niff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	o- 14. Race - American Indian, Black, White, etc.
5-0036	72 hours "natural", uresi Ex	ted by	3 ☐ Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
21215	l within iene.	Completed	(Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working DO NOT use retired	Aerospace
and		Be	Father's Name (First, Middle, Last)	18 Mother's Name (First, Mpd	e, Maider Sumame)
Maryland	2 should be and Mental is marked of reumatic av	To		Floven Ce /VL	astermaker per, City or Town, State, Zip Code)
	s 1 and 2 f Health Item 27 other tre		20a. Method of Disposition 20b. Place of Disp	pecord Rd., Gilmantor	1 LW NH 03837 20c. Location - City or Town, State
3altimore,	o o 🖵 🛌		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ematory or other place)	Baltmore, MD
Balti	permit. Pag Depertment Important: I any Injury o		21. Signature of Funanti Service Licentee	22 Craminas of Facility Services	, PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or head failure. List only one cause on each fine.	nter the mode of dying, such as cardiac or respiratory a	Approximate Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	1 Hemorrhage	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	hnord Hemorr	hage true
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S. Box	The law requires that the death certificate be execulate has been signed by the attending physicien and page 2 should be detached for use as the burial-tran	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□ Ectopic pregnancy ApROVED BY ME ICAL EXHAUM	23d. Date of delivery Month Day Year
P.0	that the de ned by the a detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ords	w requires been sign should be	ted b		10	Yes 2. No 3 Probably 4 □Unknown
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n of	ding Phys	on: To	1 XYes 2/2 No 1005/mai. 1 Inpatient 2 ER/Outpatiet 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 28d. Describe	how injury occurred Feil
isio		ertification:	2 Accident investigation April 23 200 € 0	DPM 1 Yes 2 No and for	Street and Number or Rural Route Number,
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	To the Hospital or Attenwihin 24 hours efter deatl To the Funeral Director:	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ith occurred at the time, date and place, and due to the nvestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number 6 2 9 1 2	29d. Date signed (Month, Day, Year)
			30. Name and address of person who/completed cause of death (Item 23a) (Type	Prior	1/29 2000
	Sta	te	Christine Kajubi 5401 Old Court 31. Date filed (Month, Day, Yer) 32. Registrar's Signature	Road Kandallstow	n Maryland
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	73	Decedent's Name (First, Middle, Last)			A 4		2. Date of Dea	th		3. Time of Death
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/Medic Examin	_	4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	r Location of Death		4c. County		, ,
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Funeral		5. Social Security Number 6. Sex	M 2005	last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year)	9. Birthpl	ace (State or Foreign
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and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	cation				10	Od. Inside City Limits
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Sta Sta	ato.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	UEFER	36 116	hour h	** 10/61 6	וין כי-	וידייע
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ORIGINAL

Amend item#10e, perFH, \$50,0/1/00 TT Amend item#5, perFH, 0856,6 12/06 11 Department of Health and Mental Hygiene 0 0 6 For An State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Мау 9:10p M R. 25 Helen McGrain 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Brightview Assisted Living Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5.210 Security Number 217-18-21 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F 82 17-18-2193 24,1924 Director April Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits rel', or Items 23a or 28e-f show Examiner must be notified at ty Yes 2 □ No Md Baltimore Catonsville Directo 10e. Street and Number Knollview 10f. Zip Code 10g. Citizen of What Country? 5504 Court 21228 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 4+17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is 1 and 2 should be fi of Health and Mental H item 27 Is marked ot Joseph Rochlitz Helen Tice 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Leahy - Daughter 124 Newberg Ave., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Holy Redeemer 5-31-06 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton F.H. P.A. 21. Signature of Juneral Service Licensee 2134 Willow Spring Rd. Balti. Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final homo obstructive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) _ P.O. 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be History sertermin adenocercenona 3 Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 No certificata 1 ☐ Yes Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Two-ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) complately (Check only one) and manner stated. To the within 2 ding thy SICI 429c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 Geipe Rd MD ngertH an 51 32. Segistrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 8.10f 9856 6-1-06 vt State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year MAZIE

4a. Facility Name (If not institution, give street and number) 1:07 QM FALL 2.006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner ZICHTZ HUSPICE BRUTTMORE yrs, last birthday) Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Car) **Funeral** 6 Days Hours 1 ☐ M 2 🔼 F 213-22-0541 Director Mouth to, 1910 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "natural", or items 23a or 28a-f show the Wedfall Examiner must be notified at Ma Be Completed by Funeral Director 1 Yes 2 □ No PITIMORE 10e. Street and Number 21213 10f. Zip Code 10g. Citizen of What Country? 3766 AUE 21206 AVEHWOOLL Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 Yes 22 No Specify: SIACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) NIA it of Health and Mental Hyg if item 27 is marked other or other traumatic event, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event one. 18. Mother's Name (First, Middle, Maiden Sumame) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERRIVIA RAN/NECE 3766 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Car 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 23a. Pany Enter the disease of complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Probable recta cancer /Medical Due to (or as a consequence of) Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Completed by Physician/Medical 25 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ZUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? of Vital 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA tospice 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division

2/33/06

within 24 hours after death.

To the Funeral Director: After this certific completely fillad in by the funeral director,

29b. Signature and title of certifier E. Tso MD

31. Date filed (Month, Day, Year) State JUN 0 1 2006 Registrar

3 🗌 Suicide

29a. Certifier

4 - Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

29c. License number D24170

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

May 22, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

838 Evitan St Bullimore MD 21201

Richey Hospica 82. Registrar's Signature ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink

Roger L McCrobie	1- For State Registrar	ate of Maryland		te of Death	и мена пу	giene	No 200	6 1723
Physician/ Medical Examiner	Decedent's Name (First, Middle)					2. Date of Death Month E May 28, 200	Day Year	3. Time of Death 1329 hrs
- A	Roger L. McCrobie 4a. Facility Name (if not institution			4b. City, Town, or	r Location of Death	Way 20, 200	4c. County of Death	
,	Baltimore Washingtor			Glen Burnie		lo Barant Binth	Anne Arundel	
Funeral Director	5. Social Security Number 235.74.2773 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last birtho	Yrs. If Under 1 Yes]	(MM/DD/YYYY) 9 Bir Foreig Co	untry) WV
any.	10a. State 10b. County		10c. City, Town or	Location				10d Inside City Limits
rath with the Maryland items 23a or 28a-f show any sat be notified at once.	MD Anne A	rundel	Glen Bur	nie 10f. Zip Code		1100	. Citizen of What Cou	1 Yes 2 No
tith the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number			Tor. Zip Code		Tog		ntry ?
triems 23a	301 S. Crain Hwy 11. Marital Status	12. Was Decedent		13 Was Decedent of Hi	21061 spanic Origin? (Spe	ecify Yes or No-		ican Indian, Black,
r death	1 Never Married 2 XXM	arried Armed Forces? 1 X Yes 2 orced If Yes, Give Year		If Yes, specify Cuba		Rican, etc.)	White, etc.	
rs after ural". nuiner	45 December 1 december (Con	Tor Dates.	npleted) 16a. De	1 Yes 2XX No		ork done	Specify Whi 6b. Kind of Business/	
72 hou "nat al Exa	Elementary/Secondary (0-12)	College (1-4 or	du	ring most of working life	e. DO NOT use retire	ed)		
5-0036 ed within 72 hour lygiene other than "natu the Medical Exan Completed	7 17. Father's Name (First, Middle	Lost		Laborer	18 Mother's Name		Car Cleaning	& Repair
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-1 she injury or other tranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Oliver McCrobie	Last)				arrison Mc	,	
21; hould b hd Men is mar nitic eve	19a. Informant's Name/Relations	hip (Type, Print)	19b.	Mailing Address (Stre				e, Zip Code)
, ME and 2 si ealth ar em 27 traums	Goldie McCrobie 20a Method of Disposition		unk 20b. Place of	Disposition (Name of ce	emetery,	Date	20c. Location - City or	Town, State
More Pages 1 a nent of H ant: If it	1 XXBurial 2 Cremation		ate	y or other place) Memorial Garde	ens 6.2.2	2006	Kingwood, WV	
Baltin permit P. Departme Importan injury or	4 Donation 5 Other S		- Juliace 1	22 Name and Addres	s of Facility		Kingwood, av	
	K. Gregory Fink	complications that course	M01148	1426 Crain Hw	v SW Člen Ri	urnie, MD.	21061	Approximate Interval
Physician /Medical	23a art l. Enter he d seas to a liure. List on the called	Adhen a malamatim			g. Such as calculación	respiratory arres	t, SHOCK, OF HEAR	Between Onset and Death
Examiner	Immed Cause (Final disease or condition resulting in death)	Due to (or as a cons		Discase				
	Sequentially list conditions, if any, leading to immediate	bb	equence of):					
ted Insit	cause Enter Underlying Cause (Disease or injury that initiated	c						
d d ansit	events resulting in death) Last	Due to (or as a cons	equence or):					
60, ate be executed hysician and burial - transi	UNPENDED	AMENDED						
7760 g physical but but but but but but but but but but		23c. If yes, outcome 1 Live birth	me of pregnancy	Fetal death 3	Ectopic pregnar	ncv	23d. Date of deliver	y Day Year
Box 687 e death certific the attending p ed for use as th	past 12 months?	4 Pregnant a	time of death 5	Other (Specify)		,		,
	Part II. Other significant condi	9 Unknown	h but not resulting	in the underlying cause	given in Part I	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records, P.O. tat or Attending Physician: The law requires that it is after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	`					1 Yes	2 No 3 Prol	bably 4 🗸 Unknown
tal Records, cian: The law require certificate has been si ector, page 2 should b						24a Was an autopsy	prior to	utopsy findings available completion of cause of
Reco						perform 1 Y Yes 2		es 2 No
ital Fician: ician: s certifi rector, Be (examiner?	Linea itali	ent 2 🗸 ER/Out		Other Nursing		esidence 6 Othe	
Division of Vital I pital or Attending Physician: ours after death eral Director: After this certifi filled in by the funeral director, Certification: To Be (1 Yes 2 No 27. Manner of Death	28a Date of Inj (Month, Day.)	ury 28b. Ti				w injury occurred	'
Division of spital or Attending fours after death meral Director: After filled in by the fune. Certification:	1 Natural 5 Pen 2 Accident Inve	ding stigation	real)	1	Yes 2 No			
livis lor At after d Direct d in by	3 Suicide 6 Cou	ld not be 28e. Place of Ir	njury - At home, far	m, street, factory, office	building, etc.	28f Location (Str or Town, Sta		ural Route Number, City
O file bou		hysician: To the best of m	v knowledge, deat	n accurred at the time.	date and place, and	due to the cause	(s) and manner as star	ted
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be ((Check only certifying Pone) 2 Medical Exa	miner:On the basis of exa						
E SES	29b. Signature and title of certifi				nse number		29d Date signed (Mo	inth, Day, Year)
	Theorles	4. Kg	does to the second	0.0	.M.E.		May 29, 2006	
2	Theodore King MD.	Assistant Medical		11 Penn Street, Ba	altimore, MD 21	1201		
State		2006 Registra	ar's Signature	harte)				
Registra	JUNUI	LUUU AMARAR	A Silver Ma	7-0-0-				

			For State Registrar	State of Marylar		artment of H			iene 19. No. 2 0 0 6	17237
مہ	Physici		1. Decedent's Name (First, Middle, Las	L.		NICO	L	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	ETA1	4b. City, Town, or BALTI	Location of Deat		4c. County of Death	10.0
	Funeral Director	ò	5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) Coi	nplace (State or Foreign intry) ington D.C.
	e Maryiand 8e-f ehow	ctor	10a. State 10b. County Maryland Anne A		ty, Town or Lo Pasade					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th	ai Dire	10e. Street and Number 8002 Middlebury D	rive		10f. Zip Code 211	22	10	og. Citizen of What Co U.S.A.	,
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then *natural', or iteme 23e or 28e-f show appringnts of items 27 is marked other then *natural', or items 28e or 28e-f show appringnt or other treumatic event, the Medical Examinal must be notified at another.	by Funeral Director	11. Marital Status 1 Maried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🖪 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: White	, etc.
Maryland 21215-0036	s within 72 ho piene. In then *natural the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, -Employed	luring most of wor)	rking	Home Improv	,
yland;	tould be filed Mental Hyg Parked other Patic event,	To Be C	17. Father's Name (First, Middle, Last) Robert Alex	Nicol Jr.			Patrio		Brown	
ore, Mai	es 1 end 2 st of Health and litem 27 le n r other treun		19a. Informant's Name/Relationship (Stephanie A. Gree 20a. Method of Disposition 1月 Burial 2 □ Cremation 3 □	r (Girlfriend)	8002		ry Drive	e, Pasadei	City or Town, State, Zna, Marylar Noc. Location - City or 1	nd 21122
Baltimore,	permit. Page Department Important: If any injury o		4 Donation 5 Other (Specify) Mea	22	ge Mem Pa Name and Addres Cully-Pol	s of Facility		lkridge, Ma ne P.A a, Maryland	
	hysician be executed by physician and physician and set the burial-transit	Examiner	23a Art1. Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	blications that caused the deat one cause on each line. a. HEART Due to (or as a conseq b. PERICAR Due to (or as a conseq c. Due to (or as a conseq	FAIL (uence of): CDIAL (uence of):	er the mode of dying	j, such as cardiad			Approximate Interval Between Onset and Death
.O. Box 68760,	death cert e attending d tor use	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	ildeath 3□	Ectopic pregnancy Other (specify)			23d. Date of delik Month	rery Day Year
ords, P	The law requires that the see hes been signed by the bege 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	n in Part I.		acco use contribute to	
tal Rec		e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy perform 1 Yes 2	ed? prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	ding Phys h. After this funeral di	ition: To B	examiner? 1 K Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing H		nce 6 Other (Speci	fy)
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	To the Hospitel or within 24 hours atte To the Funerel Direct completely tilled in h	Medical	one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my op	inion, death occu	rred at the time, dat	te and place, and due t	o the cause(s)
	T will		29b. Signature and title of certifier 30. Name and address of person who a	completed cause of death (Item	23a) (Tune		000		d. Date signed (Month,	
	D Sta			SILES+1(32. Registrar's Signa	600)		ST.	BALTIM	ORE, MD	21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	1 - State Registrar		artment of Health an tificate of Death		iene _{g. Ng} 2006 17238
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Earnest	Nic	ks	2. Date of Death	Day 4, 2006 12 45 0 M
	Examir		4a. Facility Name (If not institution, give street and in Maryland General) 5. Social Security Number 6. Sex	tumber) HUSAI tal 7. Age (In trs. last birthday)	4b_City, Town, or Location of C Bal Fim Re If Under 1 Year If Under 24	Crty	Ac. County of Death N.A.
*	Funeral Director		247-48-6893 1 DX4 2 DF	70 Yrs.		Min. (Month, Day, 10–1	
	ryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	the March 1 s	Director	Md. NA	Ba	ltimore 10f. Zip Code	10	1 ☐X es 2 ☐ No Og. Citizen of What Country?
	23a ol	al DI	2739 Huntingdon Ave	nue	21211		USA
396	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show lical Eractiver must be rediffed at	by Funeral	11. Marital Status 12. Was Do Armed	ecedent Ever in U.S. 13. \ Forces? I s 2 \(\text{No} \) No Give	Nas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F I ☐ Yes 2 🎇 No Specify:	? (Specify Yes or No- luerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: USA
21215-0036	⊆ - 4	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life. I	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 1	l6b. Kind of Business/Industry
	filed with Hygiene. other than	Be Co	12th grade 17. Father's Name (First, Middle, Last)	M	ail Service 18. Mother's	Name (First, Middle, M	J.H.U. Naiden Sumame)
Maryland		ToB	William	Nix	l I	Mary	
Mar	12 sho h and 7 ls mu traum		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number of		
	s 1 and 2 should of Health and Mer itam 27 Is marke other traumatic		Carolyn Nicks Wil	20b. Place of Dispo		St., Balti	Lmore, Md. 21218 20c. Location - City or Town, State
<u>m</u>	Page nent o ant: If ury or		1 Burial 2 □ Cremation 3 □ Removal fro '4 Donation 5 □ Other (Specify)	m State	n Forest Vet.	6-1-06	Owings Mills, Md.
Baltimore,	permit. Pages. Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee		Name and Address of Facility March F.H. Ho		ltimore, Md. 21202 llOl E. North Ave.
г			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final	t caused the death. Do not enter each line.			st, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	o (or as a consequence of):	RRHYHMI	a	
	Examiner		Sequentially list conditions, b				
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):			
28760,	icate be executed physician and s the burial-transit	dical Exa	that initiated events c. Due to d.	o (or as a consequence of):			
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as I	Physician/Med	in the past 12 months?	gnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	quires that t n signed by uld be deta	by	Part II. Other significant conditions contributing to	death but not resulting in the ur	ndertying cause given in Part I.		acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown
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of	g Phys ter this neral di	 	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpatien of Injury 28b, Time of Injury Injury	t 3 DOA 4 Nursii	28d. Describe how	nce 6 ☐Other (Specify) w injury occurred
Division	or Attending Fiter death. iractor: After in by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm, stri	M 1 Yes 2 No	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	(Check only 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or invancer stated.	occurred at the time, date and prestigation, in my opinion, death of	lace, and due to the car	use(s) and manner as stated. te and place, and due to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	Loher	29c. License number 8952	4	d. Date signed (Month, Day, Year) 5/24/06
_(641		30. Name and address of person who completed of	iuse of death (Item 23a) (Type, CHE VA, M.	"3", 40 Mary	land Gier	reral Hospital
	Sta Regist		31. Date filed (Month, Day, Year) 32 JUN 0 1 2006	Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 28, 2006 Year 3:00 р м Richard Paul Pfeffer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Forest Hill Harford 3400 Kreitler Road Months Days Hours Min. Jan. 1945 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 Q M 2 □ F Months Maryland Yrs. Director 215-42-5933 Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits itam 27 la marked other than "natural", or Itama 23a or 28a-f ehow other traumatic event, the Medical Evantuar must be notified at Forest Hill Md. Harford 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21050 3400 Kreitler Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Itam 27 Ia marked other than "natural", or Ita 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electronic repair self-employed 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Darone John E. Pfeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Kreitler Road, Forest Hill, Md. 21050 Lynda Kay Pfeffer/wife 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 iment of h tant: If its permit. Page Department (Important: If any injury or Highview Mem. Gdns. 6/2/2006 Fallston, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Derain a. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Cause (First) Approximate Interval Between Onset and Death Renal netastatic Immediate Cause (Final Pnysician Carcinous one month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of: Examiner burial-transit Due to (or as a consequence of) attending physician Box 68760 certificate be Physician/Medicai the as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the a detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ mobilen 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 Tyes 2 No 1 Yes Hospital or Attending Phyalcian: 24 hours after death. Funeral Director: Atter this certifice Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

State Registrar

3

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MIN (MD) 602 SOUTH ATWIT

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602 SOUTH ATWOOD ROAD #208, BELASA, MD21014

31,

2006

				1 - For State Registrer	State of Man	yland / Depa		leaith and M	Mental Hygie	ne 2 11 11 6	172	+0
				Decedent's Name (First, Middle, Las	(t)		iniouto or i	Douin	2. Date of Death	NO.	3. Time of Dea	th
		Physici		•	Parsons					Day Year		\mathbf{P}^{M}
	1	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death	1114 219 2	4c. County of Death	7.10	1
		LXXIIII		Harford Memorial			Havre de	Grace		Harford		
		Funeral		5. Social Security Number 6. Se	7. Age (1	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	9 Date of Birth	O. Diethe	place (State or For	reign
		Director		236-03-6383	ŽIM 2□F 94	Yrs.	Months Days	Hours Min.	June II,	1911 West	olace (State or For otry) Virginia	а
		P .		Usual Residence of Decedent	140	a Ch T					0.1.1	-
		r 28a-f show	-	10a. State 10b. County		Oc. City, Town or Lo	ocation			1	0d. Inside City Lir 1 X Yes 2 □	
		8a-f	octo	WV Preston	K	Cingwood]140
0		vith th	Funeral Director	10e. Street and Number			10f. Zip Code			Citizen of What Cour	ntry?	
0		a 23	ra	103 Larue Avenue	40 W - D	- :- 11 0	26537	0:::0/0		S.A.		
		er de Item	un	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
	36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	ite	
	Ş	within 72 hours after death with the Maryland ene. then "naturel", or Itema 23a or 28a-f show the Madical Examiner must be notified at	ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	16b	. Kind of Business/In		
90	15	nin 72	plet	(Specify only highest gra- Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work 1)	ing			
0	212	d with	Completed	8	College (1-401 5+)	Str	ip Miner			Coal Mining		
7	פ	be filed within tal Hygiene. Id other then event, the Me	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Maid	den Sumame)		
124	<u>a</u>	Aents Aents rked	10	Burt Ray Parsons				Albert	a Margare	t Close		
21	Maryland 21215-0036	ss 1 and 2 should be filed within of Health and Mental Hygiene. If Item 27 is marked other then "r other traumatic event, the Mai	ľ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number, Ci	ty or Town, State, Zip	Code)	
1		and 2 m 27 in 27 in ref		Jean P. Skipper	(Daughter)				d, WV 265	37		
	Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Demoval from State	20b. Place of Dispo cemetery, crei	nsition (Name of matory or other place	ce)	Date 20c	. Location - City or To	wn, State	
	Ĕ	permit. Pages 1 Department of H Importent: If Ite any Injury or ot		4 Donation 5 Other (Specify		urora Cer	netery	5/28	3/06 Au	rora, WV		
	att	rmit. pontriport y inj		21. Sign ture of Funeral Service Liven	see) -	22	2. Name and Addres	ss of Facility	ne .s, WV 262			
	<u>m</u>	89889		dennis.	Mmeere					60		- 0
	£	Physician /Medical	п	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	rdial	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	1
	П	Examiner	5	Sequentially list conditions,	Renal Due to (or as a co	tail Dr	e					
		nsit	Examiner	Cause (Disease or injury that initiated exerts)	12125	foil	150					
	,	ate be executed hysician and he burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):	,,,				····	
	760,	e be /sicia e bur	cai		ď.						I SECTION IN CO.	
	99	ufficat g phy as th							•		1757	
	P.O. Box 68	Attending Physician: The law requires that the death certificat reads. reads. metor: After this certificete has been signed by the ettending phy by the tuneral director, page 2 should be detached for use as the	Completed by Physician/Med	23b. was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date of delive	ery	
	B.	deat	100	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim		Other (specify)			Month	Day Year	
	0.	at the de by the stached	hy	9 🗌 Unknown							-	
5		es that igned to be det	Ď	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		co use contribute to the		
50 n	Vital Records,	v require been sig should b	ted	_ Ula Age					1 Tes	2 No 3 □ Prob	ably 4 Unkno)WN
3	Ö	e lawr has be ge 2 sh	ple						24a. Was an autopsy	24b. Were auto	psy findings availampletion of cause	able
رم آر	<u> </u>	The I	Š						performed 1 Yes 2 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	? death? No 1 ☐ Yes	2 No	
0	ita	sician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h Check only one			
	of V	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Othe	er: 4 🗌 Nursing Ho	me 5 Residence	6 ☐Other (Specify	y)	
		ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o lnjury	28c. Injun Worl	y at k?	28d. Describe how in	liury occurred		
ğ	Sio	eath. or: A	cati	2 Accident investigation				Yes 2 □No				
8	Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (3	- At home, farm, str Specify)	eet, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,	1
Q		Hospital or 44 hours afte Funeral Dir tely filled in I										
		To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exemone)	ysicien: To the best of m niner: On the basis of ex and manner stated	amination and/or in	n occurred at the tin vestigation, in my of	ne, date and place, pinion, death occuri	and due to the cause red at the time, date a	 (s) and manner as st and place, and due to 	ated. the cause(s)	
_		within To th comp	M	29b. Signature and title of certifier	- K. T	csai, N	29c. License	e number	29d. I	Date signed (Month,	Day, Year)	
) We		/ '	Doo	62709	(05/25/	06	
		400		30. Name and address of person who		h (Item 23a) Type,	Print)	7. 0	1. 1.	10.01		
	_)		Kartik Désai, N	1) 500 C	11	sapeake	ur; Be	Air, M	1) 210	14	
		Sta Regist		31. Date filed (Month, Day, Year) 200	16 Leven	N Ap	Mil					

				ate of Maryland /			-	_	
		11	Stata	ale of Maryland /	Certificate of			Z H H I 6	17241
			Registrar 1. Decedent's Name (First, Middle, Last)		Och imedie of		2. Date of Death	3	3. Time of Death
	Physicia		Mary Dungert	-			Month 25	Year 2006	945 PM
	/Medic Examin		4a. Fecility Name (If not institution, give street	and number)	4b. City, Town, o	r Location of Death	40	. County of Death	<u></u>
			Forest Heiren N	ursing Apr	re Caton:	skille	1	saltim	orc
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Year Aug. 15, 1	9. Birthp	lace (State or Foreign try)
	Director		213-28-4221 1 M S	75	115.		Aug. 15, 1	930 Mar	yland
	land ow		10a. State 10b. County	10c. City, To	wn or Location			1	0d. Inside City Limits
	Man)	to	Maryland Harbord		Bel Air				1 Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Cour	try?
	ath wi	ral	12 S. Shamrock Road			21014		U.S.A.	
	er de	Funeral	A	/as Decedent Ever in U.S. rmed Forces?	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	irs aft	by F	H If	☐Yes 2 🖄 No Yes, Give ear or Dates:	1 ☐ Yes 2 🗖 No	Specify:		Specify: Whi	te
ò	be filed within 72 hours after death with the Maryland tal Hygiene d other then "natural", or items 23a or 28e-f show event, The Wodical Examinar must be notified at	ted	15. Decedent's Education		a. Decedent's Usual Occup (Give kind of work done	pation	16b. h	(ind of Business/Ind	dustry
215	thin 7 e. en "r	Completed		ollege (1-4or 5+)	life. DO NOT use retire	d)			
2	ygien ygien ner th		10		Homemaker	40 Mathada Nama		wn Home	
and	be fill half	Be	17. Father's Name (First, Middle, Last) Joseph Edward Ens	a h			(First, Middle, Maidei Ertrude P	rice	
ž	should be I and Mental I s marked or umatic eve	2	19a. Informant's Name/Relationship (Type, P		9b. Mailing Address (Street				Code)
<u>S</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiens. If item 27 is marked other then. or other freumatic event, the Medical Examinat must be notified at	ï		laughter)	12 S. Shamro				3330)
ē,	s 1 ar f Hea item 3	13	20a. Method of Disposition	20b. Place	of Disposition (Name of ery, crematory or other pla			ocation - City or To	wn, State
E O	Pages lent of nt: If i		1 Donation 5 Other (Specify)		Holy Redeeme	r 6/1/20	006 Bal	timore, M	laryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health s Importent: If item 27 ti any injury or other tre		21. Signature of Funeral Service Licensee	111			imunek Fun		S
<u>m</u>	99 = 89		12 Stins		9705 Bela	ir Rd., Bo	altimore,	MD 21236	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	se on each line.	. 0				Approximate Interval Between Onset and Death
	Physician	8 9	Immediate Cause (Final disease or condition resulting in death)	ASTO INTE	STINAL K	LEEDINC	T		Onset and Deam
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
1		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence	e of):				
3760,	e Xs	lcal	d						
x 68	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as th	Physiclan/Medi	IF FEMALE:	yes, outcome of pregnancy				2010 / / / /	
Вох	ath c attend for us	lan	in the past 12 months?	Live birth 2 Fetal dea Pregnant at time of death	th 3 Ectopic pregnance 5 Other (specify)	1		23d. Date of delive Month	ny Day Year
0	tt the de by the a tached	ysic		Unknown	o de cuital (apaciny) _				
<u>α</u>	s that the ned by a detac		Part II. Other significant conditions contribu	ting to death but not resulting	in the underlying cause given	ren in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
rds	w requires been sign should be	ed b	HYPOTHYRODISM				1 ☐ Yes 2	□No 3□Prob	ably 4 Unknown
Records,	e taw requ has been je 2 shoul	plet	SCHIZOPHRENII	4			24a. Was an autopsy	24b. Were auto	osy findings available inpletion of cause of
Ä		Completed by					performed?	death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ral:	04	26. Place of Death	The second second		
of	90 -	<u>۲</u>	1 ☐ Yes 2 ☐ No Hospit 27. Manner Death 28	1 Unpatient 2 EH/C	Outpatient 3 DOA DOA 28c. Injur		ne 5 Residence		")
	fter	ton	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury Wo	rk? Yes 2 □ No	. 20001100 110W 1170	ny obbanico	
Division	al or Attending Phy after death. I Director: After thii d in by the funeral c	ifica	3 ☐ Suicide 6 ☐ Could not be	e. Place of Injury - At home,	farm, street, factory, office	2	Bf. Location (Street a.		l Route Number,
ā	s afte	Certification:	4 Homicide	building, etc. (Specify)			City or Town, Stat	θ)	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai (29a. Certifier Certifying Physician (Check only 2 Medicel Examiner:	n: To the best of my knowled On the basis of examination a	ge, death occurred at the ti	me, date and place, a	nd due to the cause(s	and manner as st	ated.
	the H hin 24 the F mplete	Medi	one)	and manner stated.	29c. Licens			ite signed (Month,	
	V V	-	29b. Signature and title of certifier	Callean	25C. Elcent	5 0.00	290. De	-Pa-10)
			Juscell V	ted cause of death (the con-	(Type Brit)	727J1		2/20/19	
	10	e	30. Name and address of person who comple	HAN1. 722	// - 0	tel Contro	Ave I R	ALTON	11) 2/208
	Sta	ate	31. Date filed (Month, Day, Year)	32 egistrar's Signature		10. 911 1.3	7 - 765	1 - 1	
	Registi	rar 🧸	JUN 0 1 2006	Breva St.	Sperke				,

		1	1 State Registrar Amend It		f Maryland / Dep				ene J. No. 2 0 0 6	17242
	Physicia	an	1. Decedent's Name (First, Middle 2511)	Pe, Last)		/00 Jn		2. Date of Death Month	Day Year 200(3. Time of Death 5: 40 F M
	/Medic Examin	_	4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County of Dea	
			Harbor Hospital	C Cay	7 Age (In way look high-day)		ore City If Under 24 Hrs.	P. Date of Birth	0.00	Abole of Chate of Family
	Funeral Director		5. Social Security Number 214-44-2518	6. Sex 1	7. Age (In yrs. last birthday) 62 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Oct 27, 19	(ear) 1943 9. 8. Co	thplace (State or Foreign ountry) MD
			Usual Residence of Decedent		02			000 27, 13	, 13	
	irylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	Director	MD Anne Ar	rundel	Glen Bur					1 ☐ Yes 2 €3 No
	a or 2	O.	10e. Street and Number			10f. Zip Code 21060		100	g. Citizen of What Co USA	ountry?
	leath	Funerai	1505 Jupp Rd	12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	erican Indian,
36	filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or Items 23a or 28a-f show ther than "naturel", or Items 23a or 28a-f show ant, the Madical Examires must be natified a	by Fun	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	orces? 2 ☑ No ve	If Yes, specify Cubar 1 ☐ Yes 2 XNo	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc. ite
9	2 hou		15. Deceder	nt's Education	16a. Dece	edent's Usual Occupa	ation	16	6b. Kind of Business	
Maryland 21215-0036	i within 72 ho jiene. r than "natur ir a Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (life.	e kind of work done d DO NOT use retired,	furing most of worl)	king		
2	illed wil Hygien other th	Соп	10		Con	cessions			Bowling In	dustry
pu	ed day	Be	17. Father's Name (First, Middle,	Last)				ne (First, Middle, Ma	iden Sumame)	
3	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve	2	William Jenkins 19a. Informant's Name/Relations	ship (Type Print)	19h Maili	ing Address (Street a	Anna Asp		City or Town State	Zin Code)
Ma	nd 2 sho lth and 27 is ma		Paul E. Redden, Si			Jupp Rd. Gle			, , o, , o, , o, , o, , o, , o, , o, ,	<i>Lip 3333</i>)
ē,	s 1 and 2 f Health item 27 other tre		20a. Method of Disposition		20b. Place of Dispo				c. Location - City or	Town, State
E G	Pages nent of h int: If ite		1xxBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5		Glen Haven), 2006 Gle	en Burnie, M	D
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service	70-	-4-	2. Name and Addres Fink Funeral 426 Crain Hv	1 Home, P.A		21061	
			K. Gregory Finl 23a. Part1. Enter the disease, o	complications that of	aused the death. Do not en					Approximate Interval Between
	Pnysician		shock, or heart failure. List Immediate Cause (Final disease or condition		RD10 - RESPIRA	CTORY FAI	WEE			Onset and Death
	/Medical		resulting in death)	a.	(or as a consequence of):			- 11		0 - 1
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J	pe tis	ine	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consequence of):					5 YEARS
v	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last		CARDIO MYOPA (or as a consequence of):	1119				70.13
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9	ifficate g phys as the	ledic		0.						ATT.
Вох	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy birth 2 Fetal death 3(□Ectopic pregnancy			23d. Date of del	
.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of death 5[Other (specify)			Month	Day Year
9	es that igned b be deta	by Pł	Part II. Other significant conditi					23e. Did tobac	cco use contribute to	the cause of death?
rds	w require: been sig should b		Aur	E ON E	HRONIC REN	AL FALL	RE	1 ☐ Yes	2 No 3 □ Pr	obably 4 Unknown
Records,	ne law re has bee ge 2 sho	Completed						24a. Was an autopsy	24b. Were at	itopsy findings available completion of cause of
Ä	sicien: The la certificate ha irector, page 3	Com						performe	d? death? Do 1 ☐ Yes	_/
Vital	cien: ertific actor,	Be (25. Was case referred to medical examiner?			-		th (Check only one)		
of	hy shis	၉	1 Yes 2 No	Hospital: 1 2	Inpatient 2 ER/Outpatie		4 Nursing m		ce 6 Other (Spe	cify)
uo	ding h. After funer	tion	1√Natural 5 Pendi	(Ador	of Injury 28b. Time of th, Day Year) Injury	Work	res 2 □ No	28d. Describe how	injury occurred	
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Ö	el or s after of Dire	Certification:	4 Homicide	buildi	ing, etc. (Specify)			City or Town, S	State)	
	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th	edical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	Exeminer: On the b	best of my knowledge, deal asis of examination and/or in ner stated.	th occurred at the time envestigation, in my op	e, date and place, pinion, death occur	and due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifie	or Par	1	29c. License			. Date signed (Monta	•
	,		1	y	LAY KHLO, M	y Ri	ES 000		MAY 25,	2006
	6		30. Name and address of person				IMARC	MD 211	25	-
	Sta Registr		31. Date filed (Month, Day, Year,	1 2006	HANOUER Agistrar's Signature	back		, III J		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:10 AM MABLE, A RAGIAND 5 27 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL BALTIMONE, MD MERCY BALTIMORE CITY CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 224-38-1256 3/24/30 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Health and Mental Hygiene. ont: If Item 27 is marked other then "natural", or Iteme 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Iteme 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No MD Director Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2159 Chelsea Terrace 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 **Black** Specify: þ 3XXWidowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12th grade Factory Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Morris Mary Lewis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harrinetta Ragland - Daughter 2159 Chelsea Terrace Balto, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges
Department of H
Importent: If Ite 1 Burial 2 Cremation 3 Removal from State Balto National Park 6-2-2006 Balto, Md 4 □ Donation 5 □ Other (Specify) March F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Enter the tiltease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fairne. List only one cause on each line. Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and Death shock, or heart fail **Physician** Chronic leidney disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Encephalopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (weeles Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Yes 2 No 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CVA, serve disorder 1 Yes 2 No 3 Probably 4 Gonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury al Work? After 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRYAN MAY, MD MERLY MEDICAC BALTIMONE, MO ZOOI CENTER 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0603 AM Physician uman 2006 MAU vances /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death **Examiner** Bayview Medical Conter Hopkins Ba 11mire If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 F Months Yrs Director 217-24-7488 05/20/1929 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or Items 23a or 28e-f show traumetic avant, the Modical Examinations to notified at 10d. Inside City Limits 1 ☐ Yes 2 🗙 No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 Hidden Stream Court 21009 United States death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: ծ Specify. 3 ¥ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Elliott Frances Beale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard A. Roman Jr. - Son 1206 Hidden Stream Court Abingdon, Maryland 21009 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 06/02/2006 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, or c shock, or heart failure. List of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and De ly one cause on each line Immediate Cause (Final disease or condition resulting in death) othmia minutes Pnysician /Medical Examiner om Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequent the burial-transit and Due to (or as a consequence of): the attending physician Box 68760 pe Physician/Medicai use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy j in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. should be respiratory tailuve 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Cerebrovascular 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performe il or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral I To the Hospital 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person

William

Greenough

2006

DHMH 17 Rev 1/2001

tho completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

MAY 30, 2006

5505 (topkins Bayriew Circle Baltimore Maryland 21224

Please Type or Print in Black Indelible Ink

Anuradna Kama		I- For State Registrar	•	tment of Health	and Menta	Re	eg No. 200	16 1721
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Anuradha Ramasamy				2. Date of Dea Month May 28, 2	Day Year	3. Time of Death 1508 hrs
		4a. Facility Name (if not institution, give street and number)			wn, or Location of		4c. County of Deatl	
		314 West 31st Street	(l l	Baltimo		Odlina IO Data of Dia	** (46-1
Funeral Director		5. Social Security Number 6. Sex 7. Age 434-77-7697 1 M 2 XF	(In yrs. las	t birthday) If Under Months Yrs	Days Hours	Min.	th(MM/DD/YYYY) 9. Bit Foreig /1979	
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r death with the Maryland or items 23a or 28a-f show any must be notified at once.	I Director	10e. Street and Number 314 West 31st Street		10f. Zip C	21211		Og Citizen of What Cou USA	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	Funeral		X No	If Yes, specify	Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	White, etc.	ican Indian, Black,
urs afte tural",	_≧	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade company)	oleted) 1	1 Yes 2X	ccupation (Give kir		Specify: Inc. 16b. Kind of Business/	dian Industry
6 72 hor an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5-		during most of worki	ng life. DO NOT us	se retired)		
within giene her the	omo.	17. Father's Name (First, Middle, Last)		Grap	hic Desi	gner Name (First, Middle, M	Design	ing
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene 77 is marked other than "natural", natic event, the Medical Examiner.	a	Ramasamy Manikam			Log	ambal Kris	hnan	
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ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is n her traumatic	-	Ramasamy Manikam Fathe 20a. Method of Disposition	20b. Pla	ace of Disposition (Name		, Owings M	ills, MD 21	
MOFE Pages 1 Ent of H nt: If i		1 Burial 2 X Cremation 3 Removal from Stat 4 Donation 5 Other Specify:	~ I	ematory or other place) roll Cremat	ion	5/30/06	Vampatasi	l MD
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum	1	21. Signature of Funeral Service Licensee	/ Cal	22. Name and A			Hampstead 4 Reisterst	
		23a. Part I. Enter the disease, or complications that caused t	ne death [Eline F	uneral H	ome Reis	terstown, M	ID 21136 Approximate Interval
Physician /Medical	ļ	failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia	io dodini b	o not onto the mode of	aying, daon do oan	alad of respiratory arre	st, shook, or hear	Between Onset and Death
Examiner	- 1	or condition resulting in death) Due to (or as a consection)	uence of):					
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74	Examiner	cause Enter Underlying Cause (2.15-25- c.r. in july that initiated events resulting in death) Last Due to (or as a consec	nuence of)					
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ox 687 eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome past 12 months? 1		2 Fetal death	3 Ectopic p	regnancy	23d. Date of delivery Month	Day Year
that the d		Part II. Other significant conditions contributing to death	but not resi	ulting in the underlying c	ause given in Part	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or attending Physician: The law requires that the stater death "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by						2 No 3 Prob	
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ivision or Attend after death Director:	catic	2 Accident Investigation unk		unk	Yes 2 X N	Dabject	strangled	
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To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of exam						
To To con	Med	and manner stated 29b. Signature and title of certifier		29c L	icense number		29d Date signed (Mor	oth, Day, Year)
JUN 1		La MozA	51		D.C.M.E.		May 29, 2006	
Roh	1	30 Name and address of person who completed cause of de Zabiullah Ali, M.D. Assistant Medical Ex	,	3a) 111 Penn Street,	Raltimore MI	21201		
O A.	ate	31 Date filed (Month, Day, Year) 32 Pegistrar'		·	Daminore, IVIL	- 21201	,	
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			For State Registrar	State of Mary	land / Dep			lental Hyg	_	06 17246
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	Examin Funeral Director		5. Social Security Number 6. 19-62-3476	asyland Media	cal Cinter yrs. last birthday, 5/ Yrs.	Bal	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	4c. County o	of Death A 9. Birthplace (State or Foreign Country) Maryland
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Baltimore,	permit. Page Department of Important: If any injury or orce.		4 Donation 1 Other (Special Signature of Financial Service Los	(M) 1 1 /7	rbutus [i	Nem. Fark 2. Name and Address W. O. Man		06 [Frbutus Onsc Bo	ito mo alago
ا	Physician /Medical		23a. Part Epror heldsease, or conshock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	19	brevasa	(ig, such as cardiac c	or respiratory arr	est,	Approximate Interval Between Onset and Death
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	Physicia		Decedent's Name (First, Middle, Last)		. Date of Death Month	Day Year	3. Time of Death
	/Medic		Shirley Mae	Smith	5	27 2006	3:15 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			8094 Quarterfield Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Severn If Under 1 Year ff Under 24 Hrs. 8	. Date of Birth	Anne Art	ace (State or Foreign ry)
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Maryland 21215-0036	should be filed within 72 hours after death with the Maryland A Mental Hygiene. marked other then "natural", or liems 23e or 28e-f show imatic event, the Macipal Examinar must be notilised at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2X No Specify:	fy Yes or No- can, etc.)	14. Race - America Black, White, e Specify: wh	
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Baltimore,	00		4 ponation 5 Other (Specify)	osition (Name of matory or other place) en Cemetery 5/31/0)6 G	c. Location - City or Tow len Burnie,	MD
Balt	permit. Page Department Importent: If any injury o		21. Signan e of Funeral Serv. Licensee M01364	2. Name and Address of Facility Sing Second Ave SW Glen	gleton F Burnie	Tuneral Home MD 21061	PA
96	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enfer the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	ifer the mode of dying, such as cardiac or r	espiratory arres	st.	Approximate Interval Between
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<u>}</u>	physic this c	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			ce 6 Other (Specify,)
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isi	death ctor: , the	Icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		f. Location (Stre	net and Number or Rural	Route Number
<u>\</u>	effer Dire	Certification:	4 Homicide determined building, etc. (Specify)	noot, radiory, office	City or Town,	State)	
	To the Hospitel or Attending Physician: The I within 24 hours effect death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and overstigation, in my opinion, death occurred	d due to the cau at the time, dat	ise(s) and manner as sta e and place, and due to	ited. the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, D	Dey, Year)
			· CONTO	00053393		1/30/06	0
	10		30. Name and address of person who completed cause of death (Item 23a) (Type CV) (CV) (CV) (CV) (CV) (CV) (CV) (CV)	Print) Anapulic Rd	Ode	entar. Ms	21113
	Sta Regist		31. Date filed (Month, Day, Year) JUN U 1 2005 22. Registrar's Signature	ule			

			For State Registrar	State of M	aryland		artment of H			lental I		ene 2 (06	172) [, (
			Decedent's Name (First, Middle,	Last)			-			2. Date of		J. NO.	4. 0	3. Time of D	eath
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	ns 23	Funerai	5999 Emerson St	12. Was Decedent	Ever in U.S	. 13. \	20710 Was Decedent of Hi	ispanic Orio	nin? (Spe	city Yes o		S.A.	e - Americ	an Indian	
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2 2	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f ehow event, if a Medical Enainfrat must be notified at	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	ient's Usual Occupa	ation during most	of worki	na	16	b. Kind of B	usiness/Ind	dustry	
21	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use retired,)	0. 1101111	'9					
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Maryland 21215-0036	id 2 sho th and 27 le mu traum	13	Diane G. Corry		Ŷ										
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	Physician	: 7	Immediate Cause (Final disease or condition	11/									0.	Interval Betwee Onset and Dea	∍n ath
	/Medical		resulting in death)	a. AEDHTOSC Due to (or as	a conseque	nce of):	rdiovascu	lar P	eart	Dise	38e		-		
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i V	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):									
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	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	су						22d Dat	e of delive		
ROX	death a atter d for u	Physiclan/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)					Mor		Day Yea	ır
oj.	at the de by the a tached	hys	9 Unknown	9□ Unknown											
ı,	The law requires that the death certific tte has been signed by the attending p rage 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death be	ut not resulti	ing in the un	derlying cause give	n in Part I.		23e. D	id tobac	co use contr	bute to the	e cause of deat	:h?
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	ding P h. After funera	inol.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury	28c. Injury Work	at ?	2	8d. Describ	e how	injury occurre	ed		
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	e Fu	edicai	(Check only 2 Medical Ex	eminer: On the basis of and manner sta	examination	n and/or inv	estigation, in my opi	inion, death	occurre	d at the tim	e, date	and place, a	nd due to	the cause(s)	
	withir To the comp	ž	29b. Signature and title of certifier				29c. License	number			29d.	Date signed	(Month, D	lay, Year)	
			Sahada	Mart	7 00	,	Ho	55	927	>		MA	30	2006	
	3	1	30. Name and address of person wh	o completed cause of de	eath (Item 2	3a) (Type, F	Print)			,		7	1	2006	
			SALVADOR SU	/us/4- 30	100	tospil	tal Dro.	nez	Ch	ros	1,	MA	ngla	3vd	
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			For State Registrar	State of Maryla	-	artment			nd Me		jiene eg. No.	20	0.6	172	250
ļģ.	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last, Amy Marie Sm 4a. Fecility Name (If not institution, give	isek		4b. City.	Town, or	Location of		2. Date of Dea Month May	Day	23 County o	Year 2004	3. Time of 0	
	Funeral Director	eı	Union Memorial 5. Social Security Number 6. Security Number 10	Hospital	s. last birthday) 8 Yrs.	,	1 t i I	nore If Under 2 Hours	Cit	y 8. Date of Birth 2 Days 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				ace (State or ry) PA	Foreign
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.O. Box 68	that the death certifical red by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pre					2	3d. Date Mont	of deliven	y Day Ye	sa r
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Vital Record	Physician: The law requires that the this certificate has been signed by the tall director, page 2 should be detach	e Completed	25. Was case referred to medical					26 Place	of Death	24a. Was a autops perform 1 Yes	med? 2. No	pri	or to com	sy findings av pletion of cau	vailable use of
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	To the Hi within 24 To the Fo	Medicai	29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	auton and/or in/		License		39U 1				(Month, D.		
1	0		30. Name and address of person who co	ompleted cause of death (Ite	om 23a) (Type,		Mor	(30)	14.	as pitte	ن ان	M	7		
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 1 200	37 Registrar's Sign	nature Ap	ule					1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 7,8 per FH C856,06/01/06dhb

Amend Items 236,91 Mary 123,27,280 First Per Mic C853,05/30/06dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 7-30 AM 26 DWI 2006 a ADYL 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Vorthwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth 19/229. Birthplace (State or Foreign (Month, Day 19/22) VTRGTNIA HOS a 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2√ F 83 Months 217-12-0552 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No RANDALLSTOWN MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4328 MARYRIDGE DRIVE 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2X No Specify: X□ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US GOVERNMENT SOC. SEC. ADMN Elementary/Secondary (0-12) College (1-4or 5+) 12TH HEALTH CLAIMS REPRESENATIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELLEN PLEASANT **HERMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAURICE P. SMITH / SON 2379 FLAX TERRACE, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) WOODLAWN CEMETERY 5/3/06 BALTIMORE CO., 21. Signature Jungal Service License 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe abdomina wound disease or condition resulting in death) Removal of gastrostomy tube Due to (or as a consequence of):

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treumatic event, the Mudical Examiner must be notified at

the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown

3 ☐ Ectopic pregnancy CERTIFICATIO

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

Dementia, Gastritis, Diabetes mellitus, Malnutrition Diverticulosis

Due to (or as a consequence of)

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

autopsy performed? 1 ☐ Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Year

2/2 No Subacut 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) unit

Unknown^M 04/14/2006 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No

28c. Injury at Work?

Patient removed gastrostomy

Tube
City or Town, State) / Sudbrook Lane
Ruxton Nursing Hone, pikesville

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check only one) and manner stated 29c. License number

29b. Signature and title of certifier Kaluh istine HOSDITALIS Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year) 2006 26

hristine a 31. Date filed (Month, Day, Year)

MAY 3

25. Was case referred to medical

5 Pending

0 2006

investigation

6 Could not be

examiner'

27. Manner of Death

Accident

3 Suicide

4 Homicide

1 XYes -2/1N

010 32. Registrar's Signature CORREL

nursing home

State Registrar

DHMH 17 Rev 1/2001

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			1 - For Amend Items Registrar	State of Manyland	Leparment of E	sealthans Death	Vental H ygien	2006	17252
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	Funeral Director		5. Social Security Number 6. Se 3.15 Usual Residence of Decedent	7. Age (In yrs. las	t birthday) If Under 1 Year Months Days			9. Birthpl Count	
	n 72 hours after death with the Maryland "natural", or items 23s or 28e-f show wittel Evaint at most be rivilited at	i Director	10a. State 10b. County 10b. State 10b. County 10b. Street and Number		Town or Location	ek	10g. Ci	itizen of What Count	Od. Inside City Limits 1 ☐ Yes 2 ☐ No try?
2-0030	hours after death tural', or Items 2:	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 250 No If Yes, Give Year or Dates:	1 ☐ Yes 25⊠ No	oan, Mexican, Puer	to Rican, etc.)	14. Race - America Black, White, e Specify: W	etc.
1717	filed within 72 h Hygiene. sther then "natu ent, the My dige	e Completed	15. Decadent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wo	rking	(ind of Business/Ind	ustry
Maryland	d 2 should be the and Mental 7 Is marked controller	To Be	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailing Address (Street	2HAR	LOTTE	Or Town, State, Zip	Code) 32,080
Baitimore,	permit. Pages 1 and Department of Heall Importent: If item 2 eny injury or other once.		20a. Method of Disposition 128 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	ce of Disposition (Name of netery, crematory or other plants)	ess of Facility	Sy BAI	ocation - City or TV	
)	Physician /Medical		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	is to ns that caused the death. The chuse on each line. Due to (or as *consequer	nub-obe	52345			Approximate Interval Between Onset and Death
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ecords, P	w requires that the de been signed by the a should be detached	by P	Part II. Other significant conditions co		ng in the underlying cause gr	ven in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the	10
ита нес	The lar ate has page 2	e Completed	25. Was case referred to medical	Jopenia		26. Place of Dea	24a. Was an autopsy performed? 1 Yes 2 No	prior to com death?	sy findings available interest of ause of
DIVISION OT VI	hys his I dii	Certification: To B	examiner? 1 X es X No 27. Manner of Death 1 Natural 5 Pending 1 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 01/12/2006 12	Bb. Time of Injury Wo 1:30 a M	her: 4 Nursing H	lome 5 Residence 28d. Describe how inju Subject fe	ry occurred	
DIN	To the Hospitel or Attending Pi within 24 hours after death. To the Funerel Director: After to completely filled in by the funera	edical Certifi	4 Homicide determined 29a. Certifier Certifying Phy	28e. Place of Injury - At hombuilding, etc. (Specify) Assisted liversician: To the best of my knowle ner: On the basis of examination	ing facility edge, death occurred at the ti	me, date and place	28f. Location (Street at City or Town, State 163 Mountain), and due to the cause(street at the time, date any	and manner as sta	sadena, MD
ì	To the H within 24 To the F complete	Medi	one) 29b. Signature and tite of certifier	and manner stated.	29c. Licens	se number	29d. Da	te signed (Month, D	
	Sta	ate	30. Name and address of person who co	1. 5 76	3a) (Type, Print)	5346 000d R	ood Glev	Burnie	10016 JM,
	Registr	rar	MAY 3 0 2006	Alas as Si	LA TON BOOK				

Susanne Tracy Scott

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 17253

Provided Examinor The provided Examinor Th			I-For State		Cei	rtificate	e of i	Death			Re	g No	6	JUI) 1	120
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30 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Day, Year) 1 2006 32. Redistrar's Signature.	To COU	Me	29b. Signature and title of certi		stated			29c. Licen:	se number			29d Da	ate signe	ed (Mon	h, Day, Year)	
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Day, Year) 1 2006 32. Redistrar's Signature			1 10 min	hail	0 0			O.C.	M.E.			May 2	28, 20	06		
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Registrar JUN U I 2006 Marie II Appeals	~	1			-AS											
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06-03497

Please Type or Print in Black Indelible Ink

Maryland / Department of Health and Mental Hygiene

		For State State of Maryland / Depar	ificate of Death	Red	No. 201	16 1799
Physician/ ical Examiner	1	Decedent's Name (First, Middle,Last) Dennis W. Scott		2. Date of Death Month May 23, 20	Day Year	3. Time of Death
Cai Examine		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c County of Deat	h
	-	Johns Hopkins Bayview Medical Center Social Security Number 6. Sex 7. Age (In yrs. las	Baltimore If Under 1 Year If Under 24H	Irs 8 Date of Birth	n(MM/DD/YYYY) 9. Bi	rtholace (State or
Funeral Director	L	219-34-0292 1XM 2 F 66	Yrs. Months Days Hours M		Forei	
any	_	Isual Residence of Decedent Oa State 10b. County 10c. City, T	own or Location		_	10d. Inside City Limits
ž .	<u>.</u>		dalk			1 Yes 2 X No
Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene trant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Oe. Street and Number 11 Liberty Parkway	10f. Zip Code 2 1 2 2 2		g. Citizen of What Cou † SA	intry?
ms 23a be noti		1 Marital Status 12. Was Decedent Ever in U.S	13 Was Decedent of Hispanic Origin? (14. Race - Ame White, etc.	rican Indian, Black,
er death with , or items 23 r must be no Funeral		1 X Yes 2 No	1 Yes 2 v No specify		Spoothy	
athral"	ઽ⊢	A lor Dates WW L L	16a Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re		16b. Kind of Business	ite Industry
ed within 72 hour lygiene other than "natu he Medical Exar Completed	חמנים	Elementary/Secondary (0-12) College (1-4 or 5+)		etired)		
build be filled within 7 Mental Hygiene. marked other than the event, the Medica. To Be Comple	<u> </u>	12 7. Father's Name (First, Middle, Last)	Steel Worker 18.Mother's Nan	me (First, Middle, M	Bethleh aiden Surname)	em Steel
be file antal H urked o vent, tl		Hartman Scott	Irma E	. Vease	1	
should and Me 7 is ma natic ev	- [9a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number o			
Health and I item 27 is			lace of Disposition (Name of cemetery, ematory or other place)	Date	20c. Location - City o	r Town, State
Pages nent of ant: If or othe			yview Crematory 5			
permit. Pages I at Department of He Important: If ite injury or other tr		1 Signat Ineral Service Licensee	22. Name and Address of Facility B r	adley-A	shton Fu	neral Home
Physician	12	3a. Part I Enter the disease, or complications that caused the death. I	PA 2134 Willow Do not enter the mode of dying, such as cardiac	Spring c or respiratory arre	Road 2 st, shock, or heart	1 2 2 2 Approximate Interval
/Medical	1	failure. List only one cause on each line. mmediate Cause (Final disease a Pulmonary hyperte	nsion complicating hyperter	nsive cardi	ovascular dis	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of)				
Per Per		Sequentially list conditions, f any, leading to immediate Due to (or as a consequence of)				
ed nsit se		cause. Enter Underlying Cause Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of)				
rou, icate be executed g physician and the burial - transit		d	DET OF A DEC CHE OC	ш		
'50', sate be execuphysician and he burial - tra	ealc		PII,27,perME,g856,6/15/06	<u>m</u>	23d. Date of deliver	
Division of Vital Records, P.O. Box 68760, within the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transicial Certification: To Be Completed by Physician/Medical Endicical Certification: To Be Completed by Physician/Medical Experience.		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg	gnancy		Day Y ear
by the death certific the death certific by the attending piched for use as the Physician!	SICE	4 Pregnant at time of deal	other (Specify)			
that the de detached for Phy		Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I		bacco use contribute to	
irres that a signed d be dete	Completed by	Cirrhosis of liver; duodenal ulcer				bably 4 V Unknown
aw requas been 2 should	Diet			24a. Was a autops perfori	sy prior to	utopsy findings available completion of cause of
The L	5		OC Dissert Death (Char	1 ✓ Yes 2		es 2 No
sician sician is certificated of Ba	۱ œ	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2	26. Place of Death (Check Place of Death (Ch		Residence 6 Othe	er:
of Vi		27. Manner of Death 28a Date of Injury (Month. Day, Year)	28b. Time of Injury 28c Injury at Work?	28d Describe h	ow injury occurred	
IVISION Tor Attendi after death. Director: d in by the f) at	2 Accident Investigation	1 Yes 2 No	204	to a delivery of the second	and Day to Nilverbary City
DIVIS	Certification	Suicide Could not be determined (Specific)	me, farm, street, factory, office building, etc.	or Town, St		ural Route Number, City
Division of Vital Records, To the Hospital or Attending Physician: The law required but the Hospital or Attending Physician: The law required to the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should confice of Certification: To Re Complete.		29a Certifier 1 Certifying Physician: To the best of my knowledg	e, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as sta	rted
To the within To the comple		one) 2 Medical Examiner: On the basis of examination ar and manner stated.		d at the time date a		
	Σ	29b, Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Mi	onth, Day, Year)
2	- 1		•		,,	
		30. Name and address of person who completed cause of death (Item	23a)		1,410	
		30 Name and address of person who completed cause of death (Item Carol Allan, MD Assistant Medical Examiner	23a) 111 Penn Street, Baltimore, MD 212	201		
Stat Registra	te		111 Penn Street, Baltimore, MD 212	201		

		4	For State Registrar	State of Ma	aryland /		rtment of H		Mental Hy	giene Reg. No.	2006	17255
Ž.	Physici		1. Decedent's Name (First, Middle, Last EUGENE WICKHAM		ND, J	R •			2. Date of Dea Month	ath Day	0,2006	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical	Cente	7	4b. City, Town, or	Location of Dea			County of Deat	
Ī	Funeral Director		5. Social Security Number 6. Se 566-24-6881	x 7. Ag XM 2□F 80	ө (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hi Hours Min		h (2°ar)	9. Birt NEW	hplace (State or Foreign untry) YORK
*		or	Usual Residence of Decedent 10a. State 10b. County BALTIM	ORE	10c. City, To		eation ERVILLE					10d. Inside City Limits 1 ☐ Yes 2 🛂 No
	death with the Maryland ma 23s or 28s-f ehow rmust be notified at	I Direct	10e. Street and Number 2300 DULANEY V	ALLEY RO	DAD WO	02	10f. Zip Code 21093	3		10g. Citi	zen of What Co	untry?
36	be filed within 72 hours after death with tal Hygiene. d other than "natural", or itema 23a or event, the Madical Examinar must be.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 If If Yes, Give Year or Dates:		lf lf	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	-	14. Race - Ame Black, White Specify:	
21212-0036	within 72 hou ene. then "neture the Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or		(Give I	ent's Usual Occupa kind of work done of OO NOT use retired BOOK KI	<i>furing</i> most of w)	orking		nd of Business/	,
and 2		Be	17. Father's Name (First, Middle, Last) EUGENE W • SWEE	TLAND				18. Mother's N	ame (First, Middle,	Maiden	Sumame)	
Maryland	2 shou and M Is mai	2	19a. Informant's Name/Relationship (7 ERICA HURTT						Rural Route Numbe			
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place ceme IECHAN	itery, crem	sition (Name of natory or other place BURG CEN	e) METERY	Date 6-2-20	6	PENNS	Town, State ICSBURG YLVANIA
Balt	permit Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licen	XAG)					ENRY W. AD MONK			SONS CO.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)				or the mode of dyin		ac or respiratory ai	rest,		Approximate Interval Between Onset and Death YEARS
ı	/Medicat Examiner	_	Sequentially list conditions	ANOXIC	a consequence a consequence	PHAL	OPATHY					DAYS
8760,	cate be executed physicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. CARDIC		IRAT	TORY ARE	REST				
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea	ath 3	Ectopic pregnancy			4	23d. Date of del Month	ivery Day Year
Д.	w requires that been signed by should be deta	þ	Part II. Other significant conditions co	ontributing to death b	out not resultin	g in the ur	nderlying cause giv	en in Part I.	23e. Did to			the cause of death?
al Records,	: The law recate has bee	Completed							24a. Was autor perio 1 Yes		24b. Were au prior to death?	itopsy findings available completion of cause of
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6	XX		30. Name and address of person who	completed cause of M. D. 760				าพรกพ ห	1ARYLANI) (21	2014	
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 1 20		rar's Signature			n c v bod bodf 2 M 1	11 3 1 top F 13 4 L	- ton A		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For the Gardiness of Pear FH Gase Cartificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Stokes May 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Union Memorial Hospital NA Baltimore Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 217-78-9858 1 ☐ M 2 💢 F Yrs. 46 08-15-1959 Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits M % 2 □ No Md Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 USA 235 N. Milton Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Head One Co. Machine Operator 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stokes Lee McCullum Francis Μ. Mamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 N. Milton Ave., Baltimore, Md. Mother Mamie Stokes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/03/2006 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Greenmount Cem. -6-2-06 21. Signature of Funeral Service Licensee 21202 22. Name and Address of Facility Baltimore, Md. 1101 E. North Ave. March F.H. East

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ettending pl ed by the detached within 24 hours aft To the Funstel Di completely filled in

Medical Certification: To Be Completed by Physician/Medical Examine

TOCELYNE

31. Date filed (Month, Day, Year)
JUN 0 1 2006

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

r than "natural", or iteme 23e or 28a-f ehow the Medical Examinar must be notified at

artment of Health and Mental Hygortant: If Item 27 is marked other injury or other traumatic event,

Depar Impor any ir

Physician

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

shock, or heart failure. List only	one cause on each line.	th. Bo not enter the m	node of dyin	g, such as cardiac	or resp	oratory arrest,		Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. Thrombo	cyte pen	ia					Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		quence of):						yrs yrs
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Ûnknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic	pregnancy (specify)				23d. Date of de Month	elivery Day Year
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examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Oth	or: 4 ☐ Nursing H	ome 5	5 🗆 Residence	6 □Other (Spe	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injun Worl	at		Pescribe how injur		
3 Suicide 6 Could not be determined		nome, larm, street, fac	tory, office		28f. Lo	ocation (Street ar	d Number or F)	lural Route Number.
29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the tin	e, date and place pinion, death occu	and du	ue to the cause(s) the time, date and	and manner a place, and du	s stated. e to the cause(s)
29b. Signature and title of certifier			29c. Licenso	number		29d. Da	e signed (Mon	th, Day, Year)
Tocelune Key	alphois, ms		ATTI	13894	6	M	26 27	70176

Union memorical Hospital.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KOWATCHOU

HAROLD B. SCHINER WAY 28, 92006 Year 1:14 46. City, Town, or Location of Death A. Facility Name (if not Prestriction, give sines and number) HOSPICE OF BALTIMORE GILCHRIST CTR. Social Security number 5. Social Security number 5. Social Security number 6. Social Security number 6. Social Security number 7. Age (if you have a favored and number) 100. City, Town or Location of Death 100. Trade 100. Inside and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number 100. Street and Number (if you find your part of your par	im <i>e</i> of Dea	0.6	No.	R eg .	2. Date of D		Death	e of L	rtificat	Cei			iddle, Last)	For State Registrar Decedent's Name (First, Middentification of the state of the s					
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year 29d. Date signed (Month, Day, Year 29d. Date signed (Month, Day, Year			Date signer	20d			number	c. License	29				rtifier	29h Signature and itle of certif	Me	5			

Registrar

JUN 0 1 2006

Division of Vital Records, P.O. Box 68760,

Amend item#11, perFH, \$656,0/5/06 TI State of Maryland / Department of Health and Mental Hygiene) 0.000 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Death Year **Physician** KELSEY 12:00 A 06 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Baltimore If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 19. Date of Birth (Month, Day, Aug. 9, 9. Birthplace (State or Foreign Country) Washington 7. Age (In vrs. lest birthdev) **Funeral** Months Days Min. 577-03-3438 93 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28a-f shor other treumatic evant, the Macical Examinar must be notified at 1 ☐ Yes 2½ No Director Baltimore Monk ton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2114 Monkton Road 21111 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiana. If item 27 is marked other then "natural" or the any Injury or other traument. 1 ☐ Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give WWII 3altimore, Maryland 21215-0020 1□Yes 2∏ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Architect Building Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Harry Y. Saint Myra Estella Kelsev P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Condict Martak (daughter) 5908 Point Pleasant Road, Balto., MD. 21206 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Svc. Corp. 05/31/06 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc, of Funerel Service Licensee 1050 York Road, Towson, Maryland 21204 Stephen Coster 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ulcer burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and Due to for as a consequence of: Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): as esn Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yes 21 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death To the Hospital or Attending Pt within 24 hours after death.

To the Funaral Director: After the completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death.

I Director: Aff 1 🗌 Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states. 29a. Certifier Medical 29b. Signeture and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

181 State

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 3 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type

			1 - For Amend Items 2 Registrar	State of Mary 3a, 25 per M	and / C E, G85	eparty Certifi	gent of H 30/06di cate of L	ealth and M Death		jiene ()	06	17259
	Physici /Medio		Decedent's Name (First, Middle, Last)	Robbie	E. Ta	aylor			2. Date of Dea Month	Day	Year 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s ST, AGNES	treet and number)	TAL	4b.	City, Town, or	Location of Death	E	4c. County	of Death Baltime	оге
	Funeral Director		220-76-3617	M 2 F	yrs. last birt		Inder 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct 2,	Year) 1949	Countr	ce (State or Foreign y) aryland
	anyland •how	20	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		. City, Town	or Locatio		ltimore			100	d. Inside City Limits 1 ★ Yes 2 □ No
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleatth and Mental Hygiene. Ifem 27 ie markad other then "natural", or itame 23a or 28a-f ehow other traumatic event, the Medical Examinar must be netified at	To Be C	17. Father's Name (First, Middle, Last) Daniel T.	Taylor				18. Mother's Name		Maiden Suman a E. Taylo		
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Baltimore,	Pages 1 a ent of Hes nt: if item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	1		y, cremator	(Name of y or other place onal Park (9)	Date 03/22/06	20c. Location -	City or Tow	
Balti	permit. Pages 1 Department of H Important: if ite eny injury or ott		21. Signature of Funeral Service Licente	1 55		-	ne and Addres		al Service, F			
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8760,	cate be executed bhysician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a con	sequence o	f):		TOWNERRO	VED BY MEDICAL			
9	0 0 .	Medi	IF FEMALE:				Q	RTIFICATI				
(←). .O. Box	The law requires that the death certificate has been signed by the attending binge 2 should be detached for use as to	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. ff yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death		pic pregnancy or (specify)		-	23d. Dat Mo	e of delivery nth D	ay Year
Cds, P	w requires that been signed b should be deta	ed by Pt	Part II. Other significant conditions conf Q VAPRA PU						1	pacco use conti	ibute to the	cause of death?
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ital	iician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Death			☐ Yes 2	⊔ No
50	Physician: this certificaral director, i	၉	1X Yes 2⊋¶e Ho		2 ER/Out		DOA Othe	r: 4 Nursing Ho				
Sign	Attending Physic results. Control of the this of the funeral dispersed the funeral disp	Certification:	27. Manner of Death 1	28a. Date of fnjury (Month, Day Year		jury M		es 2 No	28d. Describe ho			
Pia	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)				28f. Location (Sti City or Town	, State)		
	the Hos thin 24 ho the Fun mpletely f	Medicai	one) 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	nination and	or investig	ation, in my opi	inion, death occurr	ed at the time, da	ite and place, a	ind due to th	ne cause(s)
	7. <u>₹</u> ₹ 8		30. Name and address of person who cor	& m	<u>ر</u>		DOO	5/86-	5	MARCH	/ /5	2006
			30. Name and address of person who con A HABLUS 31. Date filed (Month, Day York)	repleted cause of death (Item 23a) (T	Type, Print)	U 5,	CATON	J. MOSP	BAR	TIM	oce mis
	Sta Registr		31. Date filed (Manth, Pey Year)	32. Registrar's Si	grature	new.	,		,			

				1 - For State Registrar	5	State o	f Mar	ylanc		artmen <i>tificat</i>				lental Hy	giene Reg. No.	0.0	16	1726	0
		Physici	an	Decedent's Name (First, Midd.	_									2. Date of De Month May 24		06	Year	3. Time of Dea	ath
		/Medic	cal	Carolyn D. Tem 4a. Fecility Name (If not institution		et and nur	nber)			4b. City,	Town, or	Location	of Death	may 2.		County o	f Death	1300	
		Lxamii	101	Upper Chesapea	ke Me	edical	l Cer	nter			Be1	Air					for	l .	
		Funeral		5. Social Security Number	6. Sex 1 ☐ M	2 F	7. Age (I	In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Feb. 4	th ay, Y945) 4	.8		lace (State or Fo	reign
		Director		217-50-3669 Usual Residence of Decedent		X	30		113.					reb. 4	, 107				
		arylane show	_	10a. State 10b. County Md. Harf			10	0c. City,	Town or Lo	cation	S	treet	=				1	0d. Inside City L X 1 ☐ Yes 2	
		the Misself	ecto	10e. Street and Number	.01 u					10f. Zip					10~ Chi-] NO
		3a or	i Dir	1248 Macton Ro	ad					1	2115	4			10g. Citiz		S.A.	try?	
_		within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-1 ehow ha Modical Examirar musi be notilled at	Funeral Director	11. Marital Status		Was Dece	edent Eve	er in U.S	13. \	Vas Deced	lent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.))- 1		- Americ	an Indian,	
3	36	s after	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes If Yes, Giv Year or D	2X No			Yes		Specify:		r nour n oto.		Specify:			
300 Pm	21215-0036	2 hour atural	ted k	15. Deceder	nt's Educat	ion	ates:		16a. Deced	lent's Usua	Occupa	tion			16b. Kir	d of Bus	iness/Inc	dustry	
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36	d 21	Hygier Hygier ther th	Be Completed	12 years 17. Father's Name (First, Middle,	Last)				se	creta	ry	18. Mothe	er's Name	e (First, Middle					
-	au	id be lental ked o ic eve	To Be	Joseph DeSimor										la Tena		Jamamo	,		
9	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or iteme 23a or 28a-f ehow any fujury or other traumatic event, the Macical Examinat must be notified at ance.		19a. Informant's Name/Relations Richard J. Ten			nd		19b. Mailin 1248	g Address Mact	(Street a	nd Numbe	or Run Str	a <i>l Route Numb</i> eet, Md	er, City or	Town, S	tate, Zip	Code)	
2/24/06	ore,	of Hea of Hea of Hea of Heam	-	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	2 OD-			20b. Pla	ace of Dispo metery, cren	sition (Nan	ne of ther place	») !		Date				wn, State	
35	Baltimore,	tment tant: i		4 Donation 5 Other (S	Specify)	iovai iioiii i	State	Bayv	riew C					27, 200	6 Bal	Ltimo	ore,	Md.	
7	Bal	Departiment Department of the series of the		21. Signature of Funeral Service	Licensee	Run	o K	کے م	S		nek	Fune:	ral 1	Home of ad, Bel					
				23a. Part1. Enter the disease, o shock, or heart failure. List	r complicat t only one o	tions that c	aused the	e death.	Do not ent	er the mod	e of dying	, such as	cardiac	or respiratory a	rrest,	1111		Approximate Interval Between	ņ
		Physician	10 13	Immediate Cause (Final disease or condition resulting in death)	a	0	DP1	\square										Onset and Deat	n
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26	7	*	ner	Sequentially list conditions,	b	Due to (or as a c	onealue	ence of										
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800	Вох	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c.	If yes, out 1□Live b	irth 2 [Fetal	death 3	Ectopic pr					2	3d. Date Mont		ry Day Year	
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3	ري ص	res that the igned by be detacted	by Ph	Part II. Other significant conditi	ons contrib	buting to de	ath but r	not result	ting in the ur	derlying c	ause give	n in Part I.		23e. Did t	obacco us	e contrib	oute to th	e cause of death	?
2	Vital Records,	law requires as been sign 2 should be												10	Yes 2□	No 3	□ Prob	ably 4 Onkn	own
Buroly	ĕč.	e lawr has be	Completed											24a. Was autor	osv	pri	or to con	sy findings avail	able of
20	a	ician: The l certificate ha rector, page		25. Was case referred to medica											2 No	1 [ath?] Yes	2□ No	
त्व	× ×	Physician: this certificant	To Be	examiner?	Hos	pital:	npatient	2□€	R/Outpatien	3 DO	A Othe	-		n C <i>heck onl</i> y o	101	Other	(Specific)	
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m	Ō.	i Dirig	Certification:	4 ☐ Homicide determ		buildir	ng, etc. (Specify)		·				City or Tov	vn, State)			Route Number,	
13		Hospital 24 hours a Funeral l etely filled	edicai	29a. Certifier 1 Certifyin (Check only one)	ng Physici Examiner	ian: To the : On the ba and mann	asis of ex	caminatio	ledge, death on and/or inv	occurred estigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	and mani place, an	ner as sta d due to	ated. the cause(s)	
1_		To the within 2 To the complet	Me	29b. Signature and title of certifie	ar		.s. statet	-			. License					signed (Month, L	Day, Year)	
				► Có Lell	e /	NP					1)00	063	22	0	51	124	1/2	006	
		6		30. Name and address of person George ISCKa		SOD U	e of deat	th (Item :	23a) (Type, I	Print)	1	Q	0 \ A	o C	10 4	210	14	1	
	8	Sta		31. Date filed (Month, Day, Year,)	32. R	strar's	Signatu		1-0	1	, CH		111,11	<u></u> (<u>ر ، ا د</u>	7		
		Regist	al	JUN 0	T ZUU	0	Mary 1	0	U 16										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fb 9856 6-1-06 yt.

State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** 7:40 PM Wilson Rank Alexander 05 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town or Location of Death Examiner Patroce
If Under 1 Year If Under 24 Hrs. 2409 Avenue Baltimore Haelen 5. Social Security Number 8. One of Birth Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 M 2 F Yrs Director 217-03-9455 OD/30/1914 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b County r 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 ₺ No Director Baltimore MD altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with uner 5 and 5e c ö USA 2409 Avenue 212110 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☒ No Specify If Yes, Give Year or Dates: Specify: if Health and Mental Hygiene.
Item 27 Is marked other then "natural", o
other traumatic event, Ins Madical Exer-3 ☑ Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) enan Kuan Stevedore 18. Mother's Name (First, Middle, Maiden Sumame) grade onashoreman 17. Father's Name (First, Middle, Last) Be Mitchell Mary W ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Smeach Deive, Harover, PA Nitchel Wilson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of tmportant: If it any injury or o once. tment of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/2006 DOING Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Functal Selvice 21. Signature of Funeral Service Licenses aucho 5151 Batto Natt Pike, Battimole, MD 21339 (Treene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Heard Freily. 105eurs /Medical Decudes Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tes 20 No 1 Tyes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / In by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 0 5-30-06 aleeeney 099779

State Registrar

419 W Redward St

32. Registrar's signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ouis J. Domenici (7)

31. Date filed (Month, Day, Year)

			for State	State of Maryland	d / Depa		Health ar		•	_	0.6	17262
			State Registrar Decedent's Name (First, Middle, Last)		Cel	tificate of	Death	2.	Re Date of Death	g. No. ···	UU	3. Time of Death
н	Physici	an	Boger		V	Varre	N		Month 104	Day	Year 06	8:45 AM
	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,			149	4c. Count	y of Death	8.15/1
	Exami	61	BALLIMORE VA Me	dical CONT	PR	BA	1 Ltimos				4	
	Funeral		5. Social Security Number 6. Sex	, , ,	* .	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. [Date of Birth Month, Day,			place (State or Foreign
Н	Director		214-20-3212	M 2□F 80	Yrs.		110010	Ja	an 15,	1926		yland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Lo	cation						10d. Inside City Limits
	Maryl 1 aho	ō	Maryland Baltimor	e	Balti	more						1 ☐ Yes 2 X No
	1 the	rec	10e. Street and Number			10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	h with	Funeral Director	6320 Dogwood Road				21207			IIr	i tod	States
	deat	neri		Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of f Yes, specify Cut			Yes or No-	14. Ra	ce - Americ	can Indian,
စ္တ	or its		1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2X No		T BONG THOU	, 0.0.)		w.Whit	
8	72 hours after death with the Maryland natural; or itema 23e or 28a-1 ahow dical Exantinat must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:	10- 5							
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	illed Hygin other	Be C	17. Father's Name (First, Middle, Last)		710	CO LOUY	18. Mother's	's Name (Fir	st, Middle, M			oyea
lar	Vid be Mental rked c	ToE	Cloyd W. Warren				Ade	elaide	Bower	rs.		
Maryland	2 sho and 1		19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailir	ng Address (Stree	t and Number	or Rural Ro	ute Number,	City or Town	, State, Zip	Code)
	s 1 and 2 should f Heelth and Mer item 27 is marke other traumatic		Barbara J. Shaw /		1565	0 Bushy	Park Ro	oad, W				
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	metery, crer	sition (Name of natory or other pla		Date		Oc. Location		
Ħ	nit. Pa vartmen ortant: injury		4 Donation 5 Other (Specify)			Vet. Cer		5/5/20		Crowns	sville	e, Maryland
Bal	permit. Pages Department of important: If i eny injury or once.		2 Signature of Funeral Service License	ما	1	Name and Addr	ess or Facility	Hubba	urd Fur	neral	Home,	Inc.
	_		23a. Part1. Enter the disease, or complic	cations that caused the death.							Maryı	and 21229 Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.								Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a a conseque	ence of):						-	20 Hours
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×	death certifica e ettending ph od for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnan	ісу					23d D	ate of delive	20/
Box	death s ette	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de]Ectopic pregnand] Other (specify) _	су				onth	Day Year
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ord	equir sen si ould	ted	Temploral Vac	scular D	1 E	ease			1 🗆 Yes	2 □ No	3 Prob	pably 4 Dinknown
ec	u 00 CA	ple	Dry Gano	rene				_	24a. Was an autopsy		prior to co	psy findings available mpletion of cause of
=======================================	Page 1	S							perform 1 □ Yes 2	No No	death? 1 ☐ Yes	21 No
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ō	Phys rthis ral di	5.	1 Yes 2 No	28a. ate of Injury	R/Outpatien 28b. Time of	I 3 DOA	4 🗆 Nurs		5 Resider			(v)
on	Attending r death. ector: After by the fune	tlor	t Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Inju Wo M 1	ork?]Yes 2∐No					
Division of	Atta er dez ractor by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. L	ocation (Stre	et and Num	ber or Rura	I Route Number,
۵	ital or firs after rai Dira	Cer										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th compietely filled in by the funeral	edical	29a. Certifier 1 Cartifying Phys (Check only one)	ician: To the best of my know er: On the basis of examination	rledge, death on and/or inv	n occurred at the t vestigation, in my	ime, date and opinion, death	place, and o	due to the car the time, da	ise(s) and m e and place	anner as si	tated. the cause(s)
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	⊢ s ⊢ ŏ		1/12/			P19	823			5/2	3/1	
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_/)		Michael Sa	/	10 N	GREENE	Stre.	e+BA	Ltime	Re, M	02	1201
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			1 State	State of Marylan	•		Mental Hygie	ne 2006	17263
			Registrar		Certifica	te of Death	Reg		11400
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	Euparal		5, Social Security Number 6. Set	7. Age (In yrs		der 1 Year If Under 24 Hr	s. 8. Date of Birth	9. Birthplece	
b	Funeral Director			M 20 F 84	Yrs. Month	s Days Hours Mir	s. 8. Date of Birth (Month, Day You	1921 Mary/	(State or Foreign
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	or 28	lre	10e. Street and Number		10f.	Zip Code	10g	Citizen of What Country?	
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	r dea	Funeral	11. Marital Status	 Was Decedent Ever in U Armed Forces? 	I.S. 13. Was De	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American I Black, White, etc.	ndian,
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200	within 72 hours after death wene. then "natural", or Items 23a the Medical Examinat must I	q p		Year or Dates:	1 162 Daniel 11		1.00	- Clath	,
<u>γ</u>	n 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's U (Give kind of life. DO NO1	sual Occupation work done during most of w use retired)	orking 161	b. Kind of Business/Indust	ry
7	within ene. then	mc d	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	Homema	1	1.7	lome	
0	illed I Hygi other		17. Father's Name (First, Middle, Last)	1 1 1			ame (First, Middle, Mai		
and	should be nd Mental marked c matic eve	To Be	William Johnson			Josephil	o Wilson		
3	2 should and Men is marke	-	19a, Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Addre	ss (Street and Number or F	Rural Route Number, C	ity or Town, State, Zip Coo	de)
Z	and 2 ealth a n 27 is		Leslie Johnson -	brother	719 N. Fr	emont Ave.	Balto, mo	21217	
ā,	te H		20a. Method of Disposition	20b. F	Place of Disposition (A	lame of	-	Location - City or Town,	Stete
Ē	Pages nent of ant: If its arry or o		1 ☐ Burial 2 ② Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	75 Tris (8	rematory 5	31-101 (Varsin/15	mi
Saltimor	inje		21. Signature of Juneral Service Licens	60/	22. Name	and Address of Facility	, ,	THE PARTY OF	
מ	Dep Imp	1	XM4/1/1/1	nl	Gary P.	march FH 27	Fredhilton	Pass Balto M	b alaa9
			23a. Puri Ent of the disease, or empli shock, or leart failure. List only of	ications that caused the deat ne cause on each line.	th. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest,	Aplinte	proximate erval Between
	Physician	4 13	Immediate Cause (Final disease or condition	ATHEROSO	CERDIC	CEREB	ROVASC	ILAP DISE	set and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq				ard A	74+
	Examiner	_	Sequentially list conditions,	o					
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):				
	and and I-tran	хаг	that initiated events resulting in death) Last	Due to (or as a conseq	mence of):				
Ď,	te be executed ysician and le burial-transit	cal E			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
280	death certificate be executed e attending physician and id for use as the burial-transif	adic		J					
	certif nding use a	lclan/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna				23d. Date of delivery	
X Q	atter d for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d				Month Day	Year
j.	the cay the achec	Physi	9 Unknown	9 Unknown					
က် က	w requires that the death been signed by the atte should be detached for	by P	Part II. Dther significent conditions con	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to the ca	use of death?
ğ	en sig						1 🗆 Yes	2 No 3 Probably	4 Unknown
Hecord	2 2	Completed					24a. Was an	24b. Were autopsy	indings available
	The law cate has b page 2 sl	mo					autopsy performed	death?	tion of cause of
Vitai	sicien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
0 0	8 w 5	Tol	1 Yes 2€No	lospital: 1 Inpatient 2	ER/Outpatient 3	OOA Other: Nursing	Home 5 Residence	e 6 Other (Specify)	
	ding Phy h. After thi funeral	on:	27. Manner of Death ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
<u> </u>	r Attending er death. rector: After by the funer	catl	2 Accident investigation 3 Suicide 6 Could not be		М	1 Yes 2 No			
Uivision		Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact (y)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rural Ro late)	ute Number,
_	e Hospitel or Attend 24 hours after death e Funeral Director: A letely filled in by the fi		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemi	sicien: To the best of my kno ner: On the basis of examina	owledge, death occurre	ed at the time, date and place	e, and due to the caus	e(s) and manner as stated	
	To the Ho within 24 I To the Fu completely	Medical	One)	and manner stated.					
	To With	-	29b. Signature and title of certifier	NONDE	. 2	9c. License number	29d.	Date signed (Month, Day,	rear)
1	1		Jasneen	Vallar	M	20000	Nage .	> 30/16	
d	(2)	-	Name and address of person who co	mpleted cause of death (Item	Pan.	Heimstr	AVI5 1	DAID MI	2/208
	Sta	te	31. Date filed (Month, Day, Year)	32. Pagistrar's Signa		1,441,13	11101	4140	, ,
	Registr		AUN 0 1 20	ns A	11 Locati				

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atrick Walker		Sta	te of Maryland	•	Print in Blace rtment of He				23 /24	, mg , pag , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg , g mg ,
		1- For State Registrar			tificate of De				eg No 20	06 1/28
Physicia Iedical Examin	er	1. Decedent's Name (First, Middle Patrick John	n Walker					2. Date of Dea Month May 26, 2	Day Year	3. Time of Death 1358 hrs
		4a. Facility Name (if not institution Eastern Avenue at Chu	-			y, Town, or I Air	Location of De	eath	4c. County of D Harford	eath
Funeral Director				e (In yrs. la: 23		nder 1 Year nths Days	If Under 24 Hours			Birthplace (State or reign MD
Maryland 28a-f show any 1 at once.	Director	10a State 10b County MD Harf 10e. Street and Number	ord	10c. City,		Air Zip Code		 	0g. Citizen of What (10d. Inside City Limits 1 X Yes 2 No
vith the M s 23a or 2 e notified		803 Almond Cour	rt, Apt. 5	Ever in U.S	5. 13. Was Dece	2101		(Specify Yes or No	U.S.A.	nerican Indian, Black,
	by Funeral		Armed Forces? 1 Yes 2 ced If Yes, Give Year or Dates:	X No	If Yes, spe	ecify Cuban,	Mexican, Pue	erto Rican, etc.)	White, etc.	white
72 hours	eted	15. Decedent's Education (Speci Elementary/Secondary (0-12)	y only highest grade con College (1-4 or		16a Decedent's Usu during most of v				16b. Kind of Busine	ss/Industry
21215-0036 uld be filed within 72 Mental Hygiene marked ofter than '	Complete	17. Father's Name (First, Middle, L	4 ast)		assistan			ame (First, Middle, I	retail (G.N.C.)
215 be filed stal Hy ked ol	8	John T. Walker	,					nie Zmije	,	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other trammatic event, the Med		19a Informant's Name/Relationshi John T. Walker	r (Type, Print) III/father		19b Mailing Address 812 Ben				nber, City or Town, S Md. 2101	ate, Zip Code)
ore, Nges I and to f Health I. If item other trau		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from St	ate cr	lace of Disposition (Nematory or other plan	ce)		Date	20c Location - City	
Baltimore, permit Pages I an Department of He Important: If ite	ł	4 Donation 5 Other Spe 21 Signature of Funeral Service L		Gar	rdens of F				Baltimor Bel Air,	
	-	23a. Part I. Enter the disease, or o			610 W	Mac	runela. Phail	r nome of Road Rel	Air Md	21014
Physician /Medical Examiner		23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	omplications that caused in each line. a Stab wounds (2) Due to (or as a conse) of neck	and chest	le of dying, s	such as cardia	c or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and Death
	ا ا	Sequentially list conditions, if any, leading to immediate	b	quence of)	:					-
F 15	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of)						
and tra	dical E	UNPENDED	dAMENDED							
Sox 68760 leath certificate b e attending physic for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown		2 Fetal dea	L.	Ectopic preç	gnancy	23d Date of deliv	ery Day Year
ires that the c signed by the	ò	Part II. Other significant conditio	ns contributing to death	but not res	sulting in the underlyi	ing cause gr	ven in Part I.		bacco use contribute	to the cause of death?
Division of Vital Records, ral or Attending Physician: The law requirers after death at Director: After this certificate has been sited in by the funeral director, page 2 should be a burner or a street or a should be a seen site of the funeral director.	Completed					_		24a Wasa autop perfor	sy prior t med? death	
Vital F sysician: his certifi director,	Be C	25. Was case referred to medical examiner?	Hospital:				of Death (Che	ck only one)		
of Vir Physic er this gral dir	의	1 Yes 2 No 27. Manner of Death	1 Inpatie		ER/Outpatient 3 28b. Time of Injury	DOA 28c. Injury			Residence 6 Ot	her: Scene
sion of attending Ph death ctor: After y the funeral	ation:	1 Natural 5 Pendir 2 Accident Investi	g May 26, 2006	ear)	1352 hrs		es 2 V No	Subject stab		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could determ	not be	-	me, farm, street, facto	ory, office bu	ilding, etc.	_ or Town, S	tate)	Rural Route Number, City lle Road, Bel Air, Md
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my iner:On the basis of examination and manner stated	knowledge	e, death occurred at t d/or investigation, in	the time, date my opinion,	e and place, a death occurre	end due to the caus d at the time, date a	e(s) and manner as s and place, and due to	tarted the cause(s)
F 3 F 8	ž	29b. Signature and title of certifer			2	9c. License O.C.M			29d. Date signed (#	Month, Day. Year)
	1		o completed cause of d	,	<i>'</i>	. 0:	D. III	MD 6105		
Sta	te	Mary G. Kipple MD. 31. Date filed (Month Dev. Year)	Deputy Chief Medic	al Exam		n Street,	Baltimore,	MD 21201		
Registr		2011 0 1	2000	2	The state of the s					

State of Maryland / Department of Health and Mental Hygiene 2 U U 6

			= State Registrer		Cer	tificate of	Death		Reg. No.		
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month		V	3. Time of Death
	Physici		Ambler Aller	n Wood				May 28		Year	9:30 PM
-	/Medio Examir	_	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County	of Death	
N. N.	LXdiiii		Eldercare Gardens	3		Ar	butus		Ba	ltim	ore
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		th	9. Birthpla	ace (State or Foreign
	Director		212-10-1346	[M 2□F	97 Yrs.	Months Days	Hours Min.	Sep.	.5, 1908	Vir	ginia
			Usual Residence of Decedent								
	law law		10a. State 10b. County		10c. City, Town or Lo					10	d. Inside City Limits
	Mary	ţ	MD Balti	imore		Balt	imore				1 ☐ Yes 2 XNo
	1he	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Count	ry?
	with Sa or	Funeral Director	3504 Georgetown H	Road			21227		United	Sta	tac
	eath	era		12. Was Decedent	Ever in U.S. 13. \	Was Decedent of H f Yes, specify Cuba		pecify Yes or No		- America	
	iter o	필	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ I If Yes, Give	No 1942-			o Rican, etc.)	Black	, White, e	_
21215-0036	be filed within 72 hours after death with the Maryland nial Hygiene. bd other then "naturel", or Iteme 23a or 28e-1 ehow event, if a Madical Examination must be notified.	Ď	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1945	I□Yes 2⊠ No	Specify:		Specify:	wn:	ite
ŏ	2 hou	ed	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occup	ation		16b. Kind of Bu	siness/Ind	ustry
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7	within liene.	E	12	College (1-40) 5		rsonel S	uperviso	r	Federal	. Gove	ernment
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an	hould be filed withind Mental Hygiene. Marked other then matic event, I'm M	To B	Ambler Jones Wood	1			Lou	ise Mari	e Witte		
Maryland	should and Men ie marke aumatic	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	g Address (Street				State, Zip	Code)
M	C1 10 - 10		Errol A. Wood - N	Japhow	316 9	Second Av	onue I a	nedowna	MD 2122	7	
ď	ges 1 and t of Health if item 27 or other to		20a. Method of Disposition	repliew	20b. Place of Dispo	sition (Name of		Date	20c. Location -		vn, State
و			Burial 2 Cremation 3 P	lemoval from State	1 1 1	natory`or other plac		2006	Doltinos	. М	2
ij	trant rtant	1	4 □ Donation 5 □ Other (Specify)		Loudon Pa				Baltimor	-	
Baltimore,	permit. Page Department of Important: if any njury or once.	(21. Siposture of Funeral Service Lisen	~ (LO) T	A 14	Name and Addre					
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DHMH 17 Rev 1/2001

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			Decedent's Name (First, Middle, Last)							2. Date of De			_	3. Time of Death
	Physici		Douglas Stephen	Wright. J	r					MAY	Da	26	Year 06	7:42 AM
	/Medio Examir		4a. Facility Name (If not institution, give si			4b. City,	Town, or	Location o	f Death	,	4c	County	of Death	, , ,
	Exami		Baltimore Washi	naton Med	Ctr	Gle	n Bi	ırnie	_			Anne	- Arı	undel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bird (Month, Da			9. Birthpl	ace (State or Foreign
	Director		212-42-7174	^{M 2□ F} 62	Yrs.	Months	Days	Hours	Min.	10/25	/19	43	Count	MD
	g ,		Usuel Residence of Decedent 10a, State 10b, County	140-0										
	anyla ehov	7	,		ty, Town or Lo								10	Od. Inside City Limits 1 ☐ Yes 2 ☑ No
	Me M	Director	MD Anne Aru	indel Pa	saden					1				
	with t		10e. Street and Number			10f. Zip					-		Vhat Count	try?
	eath	erai	8417 Lockwood R	Oad 2. Was Decedent Ever in U	16 12		1122			aif . V. a a a N. a		. S . Z		na faulta
	d within 72 hours after death with the Maryland jiene. r than "natural", or itema 23a or 28a-f show tre Madical Examirer most be notified at	Funerai	11. Marital Status 1 1 ☐ Never Married 2 1 Married	Armed Forces?	1.5.	If Yes, spe	cify Cubar	n, Mexican	, Puerto f	cify Yes or No Rican, etc.)	-		e - America k, White, e	
336	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2□ No	Specify:				Specify	Whi	ite
21215-0036	72 hor	Completed	15. Decedent's Educ	ation	16a. Dece	dent's Usua	al Occupa	tion			16b. K	ind of Bu	siness/Ind	ustry
215	within 7 ene. than "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wo DO NOT u	rk done di se retired)	uring most	of workir	ng	Sh	eet	Meta	al
2	filed wit Hygien ther th	Con	12		VP/S	heet	Met	al N	1ech	anic	Fal	brid	catio	on
밀	be filed htal Hygie od other	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden	Sumam	e)	
yla	should had marked marked	P	Douglas Stephen		r.			Irn	na S	tanle	У			
Maryland	2 shc and le m		19a. Informant's Name/Relationship (Typ	e, Print)						/ Route Numbe				
	s 1 and 2 should t Heelth and Men itam 27 le marke other treumatic		Joanne_Wright/W					od Ro		Pasa				
altimore,	Pages 1 are neut of Hee int: If itam		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Re		Place of Dispo cemetery, crei	natory or o	ne of ther place)	D	ate	20c. Lo	cation -	City or Tov	wn, State
를	permit. Pages Department of Important: If i eny injury or i once.		4 ☐ Donation 5 ☐ Other (Specify)	Ва	yview	Cre	matc	ory ()5/3	1/06	Ba:	ltin	nore,	, MD
Bal	Depar Impor Impor In in		21. Signature of Euneral Service Licenses	-	22	2. Name an	d Address	s of Facility	G.J	.Gonce	e Fi	uner	cal H	Home, PA
	Ø□ = • Ø		Melle									ena,	MD	21122
			23a. Part1. Enter the disease, or complic shock, or heert failure. List only one	ations that caused the deat cause on each line.	A	e) o								Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Merio Silei	ofic	under	o Vas	enlo	el c	liscas	re	•		Criser and Death
	/Medical Examiner			Due to (or as a consec	quence of):									
٠		-	Sequentially list conditions, b.	Duend (or as a conseq	uence of):									
\int	nted nsit	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diale to	-									
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9	tificat ig phy as th	edi												
Вох	h cer endin	N/N	200. Was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pr					1	23d. Date	of deliver	у
B	deal deatt	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d		Other (sp						Mon	ith [Day Year
P.O.	that the death certifi ed by the attending I detached for use as	Physician/Me	9 🗌 Unknown						-					
<u>'</u>	8	þ	Part II. Other significant conditions conti	ributing to death but not res	ulting in the u	nderlying c	ause giver	n in Part I.						cause of death?
Vital Records,	w requir been si should	Completed								1 □ Y	'es 2[□No	3 Probal	bly 4 🛣 Unknown
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isic	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not be	On Dines of Initial Ash		М		es 2⊡N		0() (0				
Division of	P E E	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	eet, ractory	, office		2	City or Tow			r or Hural i	Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funarel Director: completely filled in by the		29a. Certifier 1 Certifying Physic	cian: To the best of my kno	wledge desti	Occurred	at the time	data and	I nlace o	nd due to the	auco/-\	and ci-	nor 25 -1-1	tod
	• Ho • Fui e Fui	edicai	(Check only 2 Medical Examine one)	er: On the basis of examina and manner stated.	ition and/or inv	estigation,	in my opi	nion, death	OCCUTTO	d at the time, o	date and	place, a	nd due to t	he cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			290	. License	number		ž	29d. Date	e signed	(Month, Da	ay, Year)
			At allo	and way			0420	F20			5/	26/	06	
-	10		30. Name and address of person who com	pleted cause of death (Item	n 23a) (Type,	Print)	1			0 '		····		21/22
	/ V		Christopher deBor			HOUN	ITAIN) Rd	, , /	PASA de	ONH	, N	1)	21/22
K	Sta Registr		31. Date filed (Month, Day Year) 1 200	32. A gistrar's Signa	iture	part	F							

WRIGHT Douglas

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:20 PM 200 6 MAY RICHARD CARLETON WOODYARD, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Maryland 49 Jan. 9. Director 220-70-7813 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Lanham-Seabrook Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 238 20706-3622 7020 97th Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify: 21215-0036 Specify 3 Widowed 4 Divorced "neturel" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Roofer 11 item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname, Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Madelyn McCloskey Woodyard Richard Carleton Woodyard, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 iment of Health a 2901 Arundel Road, #104, Mt. Rainier, MD 20712 Madelyn Woodyard - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of important: If it eny injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation | 5 Other (Specify) Metropolitan Crematory 6/1/2006 Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Juneral Service Licenses 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) of to year Physician Due to (or as a consequence of) /Medical Examiner 154 e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit 0 enia resulting in death) Last Due to (or as a consequence of) Box 68760, physicien s the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No o 9 TUnknown ፩ Division of Vital Records. P. signed be del 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 ∑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Tes 2 💢 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (Inpatient 2 ER/Outpatient 3 DOA ို 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Atter 1 X Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 T Homicide within 24 hours a To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

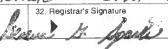
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIN SKEET SUITE 253 LAUKEL, MD AMIKALI AMJAN 31. Date filed (Month, Day, Year) State 0 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY ^{Day} 2006 9:17P M Physician 17 MAGALI ZUNIGA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) , Funeral Hours Days Min 1 ☐ M 2 🗷 F Yrs 22 1968 MEXICO 37 JUNE Director 573-15-2291 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "netural", or iteme 23s or 28s-1 ehow other traumatic event, the Modical Examinar must be coulded at Yes 2 No MONTGOMERY SILVER SPRING Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with U.S.A. 20901 11200 LOCKWOOD DRIVE death Funeral 14. Race - American Indian. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If Item 27 is marked other than "netural", or Item eny Injury or other traumatic event. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DAY CARE Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 'S AITDE PRTVATE 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SANJUANA SILVA **JESUS** ZUNIGO 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19a. Informant's Name/Relationship (Type, Print) 11200 LOCKWOOD DRIVE SILVER SPRING, MARYLAND 20901 SONE/HUSBAND GEORGE 20b. Place of Disposition (Name of cemptery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 Burial 2 Cremation 4 □ Donation 5 □ Other (Specify) RXVERDALE CREMATORY 5/27/06 RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Sent ture of Funeral Servicensee 7474 LANDOVER ROAD LANDOVER, MARYLAND d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. disease, or complications that cause lailure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG ANCER Physician /Medical Due to (or as a consequence of) Examiner METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use es the burial-transit Due to (or as a consequence of) led by the attending physician detached for use es the buria Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check only one Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Minpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s efter deu. ral Director: Aftr hy the fir 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 T Homicide within 24 hours e To the Funeral E the Hospital 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name HOSPITKI 30001 GEORGE DONALD

State Registrar

31. Date filed (Month, Day, Year) JUN 0 1 2006



			For State Registrar	State of Ma	aryland		irtment of H		d Mental	Hygiene	21111	6 1726	9
	Physici /Medio		Decedent's Name (First, Middle, Rella	Fern	All	bright			2. Date Mon		Yes		м
jî	Examir			eart Hos	spita			berlo	and	1	County of D		
	Funeral Director		5. Social Security Number 218-34-4268 Usual Residence of Decedent		88	t birthday) Yrs.	Months Days	If Under 24 H Hours M	in. 8. Date (Mon JU	of Birth oth, Day, Year) In 26, 1	917	Birthplace (State or Foreig County) MD	חנ
	Maryland I-f show	tor	10a. State 10b. County	gany	10c. City, 1	Town or Loc	berland					10d. Inside City Limits	
	th with the 23a or 28s	al Director	10e. Street and Number 13317 Valley Re	oad, NE			10f. Zip Code	21502		10g. Cit	izen of What	•	
920	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene. All other than "natural", or teme 23a or 28e-f show other than "natural", or teme 20a on 28e-f show event, the Madical Examiner must be mailfied at	by Funeral	11. Marital Status 1 Never Married 2 Marrier 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes erto Rican, et	or No-	Black, W	merican Indian, thite, etc. White	
Baltimore, Maryland 21215-0036	d within 72 ho piene. r than "natur ine Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	+)	16a. Deced (Give i life. C	ent's Usual Occup kind of work done OO NOT use retired r Aide	ation during most of w	working		ind of Busine	ss/Industry Co. Health	
/land	should be filed nd Mental Hygie marked other umatic event, it	To Be C	17. Father's Name <i>(First, Middle, La</i> John Raymor		er			18. Mother's N		Aiddle, Maiden	Sumame)	padwater	
, Man	s 1 and 2 sho if Health and I item 27 is mu other traums		19a. Informant's Name/Relationship Ellen Albright	(Type, Print) daug	approximately and the		g Address (Street 17 Valley	and Number or Road, I	Rural Route I VE C	Number, City o Sumberl	or Town, State and	MD 21502	
imore	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cem	etery, crem	ation (Name of atory or other place norial Park	ce)	Date 5/25/		umberl	or Town, State and MD	
ga	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Lic	AM	M		Name Scarpe 108 Vir	ginia Ave	nue: Cu	mberland	d, MD 21	502	
	death certificate be executed Example of the prize transit of the prize as the burial-transit of the prize as	dical Examiner	23a. Part1. Enter the disease, or content of the second of	b. Due to (or as a c. Due to (or as a d	consequent	EN;	+L FA			ory arrest,		Approximate interval Between Onset and Death	
	the death certifica y the ettending ph iched for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal de	ath 3 🗀	Ectopic pregnancy Other <i>(specify)</i>			-	23d. Date of d Month	delivery Day Year	
ras, r	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	SPLASIA	t not resultin	ng in the un	derlying cause give	en in Part I.	23e.		_/	to the cause of death? Probably 4 □Unknown	,
Hec	The lay ate hes page 2	e Completed	25. Was case referred to medical						10		24b. Were prior to death?		•
_	To the Hospitel or Attending Physicien: within 24 hours efter death To the Funerel Director: After this certific completely filled in by the funeral director.	ToB	9xaminer? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Autural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he	Year) 28	Outpatient b. Time of Injury		4 🗆 Nursnig	Home 5	only one. Residence 6 cribe how injury		oecify)	
	urs efter d urs efter d aret Direct illed in by		4 Homicide determine	building, etc.	(Specity)				City	or Town, State,)	Rural Route Number,	
	thin 24 ho the Fun mpletely f	Medical	29a. Certifier 1 ✓ Certifying I (Check only one) 2 → Medical Ex	Physicien: To the best of aminer: On the basis of e and manner state	examination	dge, death and/or inve	estigation, in my op	oinion, death oc	ce, and due to curred at the	time, date and	place, and du	ue to the cause(s)	
)			> Holenstran	0 9- 12	enery	2m	D	-1486	5		21	nth, Day, Year)	
	2		30. Name and address of person wh	GAR RAS	rence	20		N DRI	ve C	umbe	200	D,MD 2120	52
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	32. Registrar	S Signature	booste	'						

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month **Physician** Emmanuel Anele 15°, Anyanwu 2006 12:05P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Laurel Regional Hospital Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Aug. 5, 1946 9. Birthplace (State or Foreign Nigeria **Funeral** 1X M 2□ F 59 212-92-2906 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f ehow the Medical Examiner must be notified at Maryland Prince George's Hyattsville 1 Nes 2 No Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö 3210 Cherry Mill Drive 20783 or Items 23a United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural; or Item eny Injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (022) College (1-4or 5+) Self Employed Cab company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nwachkwu Anyanwu Esther (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3210 Cherry Mill Drive Hyattsville, Maryland 20783 19a. Informant's Name/Relationship (Type, Print) Peninnah O. Anyanwu -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Family Compound 5/31/2006 4 □ Donation 5 □ Other (Specify) Imo State, Nigeria 21. Signature of Funeral Ser, ice Lice se Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Oropharyngeal Dysphagia 6months /Medical Due to (or as a consequence of): Examiner Lou Gehrig's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypocalcemia; Malnutrition been s 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has t irector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34860 May 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oleg B. Shpak, M.D. 9470 Annapolis Road, #210 Lanham, Maryland 20706 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 Registrar

			1 - For State Registrar	State of	Maryland	/ Depa		t of H	ealth a	and M	-	łygie	ene . No.2 () (06	1727	7
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	Funeral Director		5. Social Security Number 218–30–1236	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. Ias 70	t birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of (Month), 9/15/	Pinth 193	62r)	9. Birthp Coun Mar	lace (State or Fo try) yland	reign
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	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	a C	29a. Certifier	Physician: To the b	sest of my knowle	dge, death	occurred a	t the time	date and	Inlace a	ind due to th	0 031186	o(s) and man	nor as sta	tod	
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	To the within 2 To the complet	×	29b. Signature and title of certifier				29c.	License	number			29d. i	Date signed	(Month, D	lay, Year)	
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	78		30. Name and address of person v	vho completed cause	of death (Item 23	a) (Type, F	Print)									
	4		Helen M. Balda				Drive	, Sa	lisbu	ry,	MD 218	301				
• 4	Sta Registr		31. Date filed (Month, Day, Year) MAY 1	2006	gistrar's Signature		made s									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARTHA BURGESS May 11, 2006 1:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3101 Kayson St Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. May 29, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ X Maryland 212-24-2897 78 Director Usual Residence of Decedent mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland sertment of Health and Mental Hygiene. ortent: If item 27 is marked other than "natural", or iteme 23e or 28e-1 show injury or other traumatic event, the Madical Exeminat must be notified at 10d. Inside City Limits 10a State 10c. City Town or Location 10h County 1 Yes 2 No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Kayson 20906 U.S.A. St Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Movidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co. Elementary/Secondary (0-12) 7th College (1-4or 5+) Night Leader Pulic Schools Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Groomes John T. Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Clarke - Friend 3101 Kayson St Silver Spring, MD 20906 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or once. Metro Fnrl. Svcs 5/18/06 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Sonature of Funeral Service Licensee 246 N. Washington St Rockville, MD20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires thet the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, the attanding physicien IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an paga 2 autopsy performa certificate HRONK 1 ☐ Yes 3/2 To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year, leted cause of death (Item 23a) (Type, Print) 13018 GORGIA FRANCISCO A 31. Date filed (Month, Day, Year) Registrar's State 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10 10 M MICHELLE BATES MAY 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAURER REGISTATE INSPITA PRINCE LAURGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 K F Director 226-84-4603 47 JAN 17, 1959 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits rai', or iteme 23a or 28a-f ahov Examiner must be notified at Director 1 ☐ Yes 27 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 Fairland Road 20904 filed within 72 hours after death Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give The Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☑ Divorced White "natural", al Hygiene. I other than "natura event, the Modical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Airline Reservation Agent Airline treumatic avent, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil iment of Health and Mental H tant: If item 27 is marked ott jury or other treumatic aven ပ Lawrence John Paszek Mary Ann Carter 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lawrence J. Paszek/Father 11612 Clipstone Lane, Reston, VA 20191 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 【☐ Removal from State permit. Page Department o Important: If any injury or offer 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/18/2006 Beltsville, Maryland 21. Signature of Funeral Service Licensee Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, MD M00956 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Physician ACUTS NESPINATURY 2014 /Medical Due to (or as a consequence of): Examiner Momons 5 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of): Examine sicien and burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medicai as the IF FEMALE: USB 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery igned by the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPTIC Completed 1 Yes 2 XNo 3 Probably 4 Unknown TRACT INFERTURN unnon 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 Dolo within 24 hours after death.

To the Funerei Director: After the completely filled in by the funeral. 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel I Hospitei 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) bullyang on 736974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21544 DAVID U NYANJOM MD 13724 LITTLE PATURENT DICKY COZUMBIA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 17 2006 Registrar

			1 - For State Registrar	State of Maryland				ealth a Death	and M		Reg. No.	200	16	1727	and and
	Physici	an	Decedent's Name (First, Middle, Last JAMES OTTOMER BE							2. Date of Dea	ath Day I Q		ar	Time of Death	
4	/Medic	al	4a. Facility Name (If not institution, give			4b. City	Town, or	Location o	of Death	<u>l'lay</u>	11	County of D	00	701	_
	Examin	ier	Washington County				ersto				Wa	ashino	rton	County	
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. I		If Unde	r 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da	h	0	Birthplace Country)	(State or Foreign	į –
	Director		217–30–5667 12 Usual Residence of Decedent	ØM 2□F 69	Yrs.					Sept.	9,19	36 M	aryl	and	_
	land low		10a. State 10b. County	10c. City	, Town or Lo	cation							10d.	Inside City Limits	_
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Maryland	and and		19a. Informant's Name/Relationship (7 Deborah L. Beaver	' .' '	1	-				I Route Numbe iamspoi				^{de)} 21795	
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al‡i	그런 변경 .		21. Signature of Funeral Service Licen	12.00	22	Name a	nd Addres	s of Facilit	v						
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			23a. Part1. Enter the disease, or come shock, or hear failure. List only	lications that caused the death one cause on each line.	n. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rrest,		Int	proximate erval Between nset and Death	
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	To the Hospital or Attend within 24 hours eiter death To the Funeral Director: completely filled in by the t	edical Certification;	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigatio	d at the tin	ne, date an pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manne I place, and	r as state due to the	d. e cause(s)	-
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, Al	4-6		30. Name and address of person who	completed cause of death (Item	. /	Print)	10-	+ C	111	4	1-	tour.	iter-	MD	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		7	,	,						21740)
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State Registrar Simora Eng

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** William Robert Brumbaugh 12, 2006 May 12:58 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1039 North Market Street Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 15, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1082 M 2 ☐ F 77 **Director** 165-22-7507 1928 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15201 Elkridge Way 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1946—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 1949 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Ie marked other than eny injury or other traumatic event, the Mes College (1-4or 5+) Elementary/Secondary (0-12) Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Chester Brumbaugh Catherine Alderdice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Duncan / Daughter 1039 N. Market St., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 15, 2006 Frederick, Maryland Resthaven Crematory 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Furthern Tylce Licerus e 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List prily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer of Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence School Other (Specify) Hospital: ٩ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ical Certification: Division 1 ☑ Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier tentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and inanner stated. 29b. Signature and title b frier 29c. License number 29d. Date signed (Month, Day, Year) D 31912 May 15, 2006 30. Name and address of Person who completed cause of death (Item 23a) (Type, Print) Julio Menocal, M.D. 1504 Opossumtown Pike, Frederick, MD 21702 31. Date filed (Month, Day, Year) MAY 16 State 2006 Registrar

p-			Amend Items 1	Type or Print in Black 22 per Dr/FH 6856 State of Maryland / D	t Indelible Ink. Ensure A 0,06/01/06dhb epartment of Health and	All Copies Mental Hyd	Are Legible.	
			1 - State RegistrarWCHD/SH 5/1		Certificate of Death		eg. No. 2 () () (1727
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36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel; or Iteme 23a or 28e-f ehow eny Injury or other traumatic event, I'm Medical Exertinar must be notified at ODDE.	y Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 3 ☐ No Specify:	o Rican, etc.)	Black, Whit	e, etc.
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Baltimore,	permit. Depertrimportri	-	21. Signature of Funeral Service Licen-		22. Name and Address of Facility	innich Fu	meral Homo	
_	70E 2 9		Maleux &	mli-	415 E. Wilson Bly	d.,Hager	stown, MD 2	1740
	215		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Finat	dications that caused the death. Do not one cause on each line.	of enter the mode of dying, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a VINtricula	~ Fibrillation			
	Examiner			Due to (or as a consequence of): - _ e			
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of).			
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Obesity				
o,	e be executed sicien and e burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):			
	te be ysicie	cal		a. obesity				
99	rtifica ng ph as th	Med	15.55		iii@			
Вох 68	th cer endir r use	an/A	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death	3 □Ectopic pregnancy		23d. Date of deli	very
P.O.	The law requires that the death certificate sie hes been signed by the ettending phy: pege 2 should be detached for use as the	by Physician/Medic	in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	4□PregnanI at time of death 9□Unknown	5 Other (specify)		Month	Day Year
ص ّ	that ned by deta	y Ph	Part II. Other significant conditions co	entributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Records,	quires n sign	b b	Sleep	Aprica		1 ☐ Ye	s 2 No 3 Pro	obably 4 Unknown
8	s been signal	lete	- ()	,		24a. Was ar	24b Were au	tonsy findings available
æ	The la	Completed				autops	ned?// death?	topsy findings available completion of cause of
ā	en: ' tifice tor, p	0	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2		213 No
>	ystci is ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outp	Other		nce 6 □Other (Spec	u(v)
0	neral	Ë	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury al	28d. Describe ho		
Sio	endir eath. or: A the fu	catle	2 ☐ Accident investigation		M t ☐ Yes 2 ☐ No			
Division of Vital	of or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	To the Hespitel or Attending Physicien: The law within 24 burus after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	calc	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the best of my knowledge, of ner: Od/the basis of evamination and/	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the ca	use(s) and manner as	stated.
	the hin 24	Medical	1	and manner stated.				
	2 <u>₹</u> € §		29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month	Dey, Year)
8	P				D0057285		51	
,			C. Valadle	ompleted cause of death (Item 23a) (Ty	MA WILL + Chant	1	S. Jales alsk	21200
	Sta	te	31. Date filed (Mointh, Day, Year)	32. Registrar's Signature	In Mailan Theri	Hayer	stemn (IND	, 61740
	Registr	ar	MAY 1 1 20	06 Brown A. p.	perce			

			1 - For State Registrer 1. Decedent's Name (First, Middle, Las.	State of Ma	arylan				ealth and Death		Reg. N	200	6 1	7278
	Physici /Medi	cal	ANNA MAE CREED							2. Date of Month	1 /5	2006	. 19	re of Death
<i>)</i>	Examir	ner	4a. Facility Name (If not institution, give ININSULA SEGNOW 5. Social Security Number 6. Se	of Media	16	Juf (1) last birthday)		Town, or	Location of De Alsoh If Under 24 F				m ici	
	Funeral Director			М 2万 F	91	Yrs.	Months	Days	Hours M	in. 12-31	Birth Day, Year -1914	JAM	thplace (Statements)	N. Y.
	Ba-f ehow	Director	DE SUSSE	X		y, Town or Lo								le City Limits Yes 2√ No
	th with the	al Dire	19206 LOWES ROAD				10f. Zip		19966		10g. C	itizen of What C US		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28s-f show other traumatic event, the Marical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Was Dece f Yes, spe I ☐ Yes		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Am Black, Whi		٦,
1215-0	within 72 ho ene. then "natur ne Medicel	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	life. I	lent's Usua kind of wo DO NOT u	rk done d se retired,	uring most of v	vorking		Kind of Business	,	
Maryland 21215-0036	should be filed and Mental Hygie marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) RICHARD LEWIS HAR	TLEY					DAISY		dle, Maidei			
re, Mar	s 1 and 2 sh Health and Item 27 is m other traum		19a. Informant's Name/Relationship (T) ALFRED CREED — SO 20a. Method of Disposition		20b. P	19206	LOWE	S RO	AD, MIL		DELA	or Town, State, WARE 19 ocation - City or	966	9
Baltimore,	permit. Pages Depertment of I Important: If It any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipens		1		OF	DELM	ARVA 05		DEL	MAR, DE	LAWARI	
<u> </u>	80 E E B		23a Part Frier the disease or como	1 Stork	the death	70)5 EA	ST M	AIN STR	EET, SAL	ISBUR	Y,MARYL	AND 21	
	Physician /Medical Examiner the prijal-transit the	dical Examiner	23a. Part. Enter the disease, or companies, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Oue to (or as a	Consequence Consequence	yopan uence of): TREMU uence of): To Th	MY	nyr	RATIO)			Interval	Between nd Death
O. Box 68	ath certifi ttending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/onths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 0 9 □ Unknown	Petal	Ideath 3□	Ectopic pr Other (sp					23d. Date of del Month	livery Day	Year
rds, P.	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions con	ntributing to death bu	t not resu	ulting in the ur	derlying c	ause give	n in Part I.		d tobacco	use contribute to		of death?
		Completed	40-20-20-20-20-20-20-20-20-20-20-20-20-20							24a. W au pe 1 ☐ Yes	topsy	24b. Were au prior to death?	Itopsy findin completion of	gs available of cause of
1	ysician: is certifice director, p	To Be	25. Was case referred to medical examiner?	lospital:	1 2 🗆	ER/Outpatient	3 DO	Otho		eath Check on		6 □Other (Spe		
Division of	tanding Physication. Ior: After this the funeral di		27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	,	28b. Time of Injury		Bc. Injury Work		28d. Describ			city)	
DIX	or At offer Olirect in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	(Specify	/)				City or	own, State	•		umber,
	To the Hospital within 24 hours extended to the Funeral I completely filled	edical	29a. Certifier Certifying Physics (Check only one) Certifying Physics Certifying Physics (Check only one)	sician: To the best of ner: On the basis of and manner stat		wledge, dasth tion and/or inv	occurred estigation,	in my op	nion, death oc	ea, and dua to the curred at the tim	e, date and	and manner as place, and due	stated. to the caus	Θ(S)
	To the Comp	W	29b. Signature and title of certifier	>			1	License	number 433		29d. Da	te signed (Monti	n, Day, Year)
9	M		30. Name and address of person who co	empleted cause of de	ath (Item	23a) (Type, F	Print)	SPIL	H SHIRLY	MD 2	1804			
*	Sta Registr		31. Date filed (Month, Pay, Year) NAY 1 8 2	32. Fegistrai	s Signat	ture	asti	,						

		1 - For State Registrar		aryland / De	partment	of Health and of Death	Mental Hy	giene Reg. No.	006 1727
Physicia /Medica Examine	al -	Decedent's Name (First, Middle, Las Edna Edna Aa. Facility Name (If not institution, give	a V	irginia		line Town, or Location of De	2. Date of De Month May	2 9	3. Time of Death 2006 3:00 A
Funeral Director	1	Frederick Memo	rial Ho		From Months	ederick	rs. 8. Date of Bir	th iy, Year)	g. Birthplace (State or Foreign Country) Maryland
the Maryland 28a-f show	Director	10a. State 10b. County Maryland Freder: 10e. Street and Number	ick	10c. City, Town o		Corte		10a Citizen	10d. Inside City Limit 1★ Yes 2 N
U36 urs after death us aff, or Items 23	by Funeral	10 Poplar Street 11. Marital Status 1 Never Married 2 Married 3 \(\frac{\text{Y}}{\text{Widowed}} \) 4 \(\Divorced \)	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		2	1773 ent of Hispanic Origin? fy Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.))- 14.	USA Race - American Indian, Black, White, etc. weity: White
d 21215-0036 filed within 72 hours at Hygiene. other then "naturel", or ent, the Modical Earth	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 7	ucation de completed) College (1-4or	5+) (G	ecedent's Usual Bive kind of work e. DO NOT use memaker	Occupation done during most of w a retired)	vorking		of Business/Industry
Maryland 212' d 2 should be filed within th and Mental Hygiene. It is marked other then traumatic event, the	To Be C	17. Father's Name (First, Middle, Last) John Edwin King 19a. Informant's Name/Relationship (7)	ina Print)	40h M	la illa an Audela	Ann	ie Pearl	Toms	
Ore, Mar les 1 and 2 sho of Health and if item 27 is m or other traum		Elsie Warnock/ne 20a. Method ol Disposition 1 \overline{\Delta} Burial 2 \overline{\Delta} Cremation 3 \overline{\Delta}	ice	20b. Place of D	Locust	Court, Mic		Mary	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other		4 Donation Other (Specify 21. Signature of Funeral Service Light)	Cluster	22. Name and	es Cemt 6-2 Address of Facility s Funeral	504	Main	rick, Maryland Street le, MD 21773
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only of the shock of heart failure. List only of the shock of the	a. Sover	d the death. Do not ne. a consequence of a consequence of	enter the mode Pailur plros *	ol dying, such as cardi	iac or røspiratory ai	rrest,	Approximate Interval Between Onset and Death
tte be nysicia	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d23c. If yes, outcome	2 Fetal death	3 Ectopic pre			23d	. Date ol delivery Month Day Year
o 8 5 8 .	2	Part II. Other significant conditions or	ontributing to death b	out not resulting in th	e underlying ca	use given in Part I.	23e. Did to		contribute to the cause of death?
VITAL RECC	e Completed	25. Was case referred to medical				00.00	1 ☐ Yes	osy rmede 201 No	4b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
hy hy	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpation 28a. Bate of Inju	ırv 28b. Tim		Other	Heath (Check only of Home 5 Residence 128d. Describe h	dence 6	
= = 0 >	i Certification:	3 Suicide 6 Could not be determined	building, et	ury - At home, farm c. (Specify)	, street, factory,	office	City or Tov	vn. State)	umber or Rural Route Number,
e c e a	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	vsician: To the best iner: On the basis of and manner st	it examination and/o	29c.	t the time, date and plan my opinion, death oc	curred at the time,	date and pla	d manner as stated. ice, and due to the cause(s) igned (Month, Day, Year)
Stat Begistra		30. Name and address of person who of Robert L. Kaufman. 31. Date liled (Month, Day, Year)	m MD 30		pe, Print)	t, Frederio		701	1/00

			For State Registrar	State of Maryland			of Health of Death			iene 2 ()	06	172	80
16	Physicia /Medic	al	Decedent's Name (First, Middle, Last) Ezra Eugene Dive Aa. Facility Name (If not institution, give s	lbliss, Sr.		45 Cibi To			2. Date of Dear Month	24 20	Year	3. Time of De.	P _M
i in the second	Examin Funeral Director	er	Washington County 5. Social Security Number 6. Sex	Hospital	ast birthday) 69 ^{Yrs.}	Hage	erstown Year If Under Days Hours	r 24 Hrs.	8. Date of Birth (Month, Day,	, Year)	ingto	ace (State or Fo	oreign
936	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Introduction: if flems 23a or 28a-1 show any njury or other traumatic event, the Medical Examinar must be netitied at 90ce.	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County PA Fulton 10e. Street and Number 3024 Wertzville	Ne	r, Town or La	10f. Zip C	238 nt of Hispa <i>n</i> ic Or y Cuban, Mexica	rigin? (Spec n, Puerto F	1	USA	Vhat Count - America - , White, e	od. Inside City L 1 ☐ Yes 2 [try?	
Maryland 21215-0036	be filed within 72 hou to Hygiene. od other then "nature event, to Medical E	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle, Last)	cation a <i>completed)</i> College (1-4or 5+)	(Give	DO NOT use	done during moretired)	er's Name	(First, Middle, I	Constru	siness/Ind	ustry	
Baltimore, Maryla	permit. Pages 1 end 2 should Department of Heelth and Mer Importent: if Item 27 is marks any injury or other traumatic once.	То	Ernest Fink 19a. Informant's Name/Relationship (Ty, Ezra E. Divelbliss 20a. Method of Disposition 1 \(\mathbb{X} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) 4 \(\mathbb{D}\) Onation 5 \(\mathbb{D}\) Other (Specify) 21. Sinature of Funeral Seconds 20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, Jr./Son	5535 lace of Dispo emetery, crer easant	Pious sition (Name matory or othe Grove	Ride R	d Ber 05/27/	keley S 106 _ I	r, City or Town,	WV 25 City or Tov	54 <u>11</u> wn, State	
1760,	Physician and Medical Examiner and print-transit	Ilcal Examiner	23a. Part1. Enter the disease, or compositock, or heart failure. List only shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	JUDAN Jence of):	rove Find the mode of the mode	1)	Home, I	P.A. Hat respiratory arm	ncock, M	1	50-0368 Approxmate Interval Betwee Oriset and Dea O' UY C	en
P.O. Box 68	deeth certific e ettending p id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic preg				23d. Date Mor	e of deliver	y Day Yea	ır
ords,	requires been sign should be	Completed by Ph	Part II. Other significant conditions con Chappic Obst PNEUMONS (A	ntributing to death but not less	ulting in the u		Se given in Part	1. Y	/	in 24b. V	3 ☐ Proba	sy findings ava	nown
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funerel Director: Attenthis certificate hes completely filled in by the funeral director, page 2 to	To Be	27. Mann of Death t Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Other	ursing Hom	Check only on		ar (Specify,		
Divis	epital or Att nours after de nerel Direct / filled in by t	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	y) wledge, deat	h occurred at	the time, date a	nd place, a	City or Town	ause(s) and ma	nner as sta	led	
	To the Ho within 24 t To the Fu completely	Medical	29b. Signature and little of certifier	ner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in	n my opinion, de	ath occurre	d at the time, d	ate and place, a	and due to	the cause(s)	
-	3 Sta Regista		30. Name and rouless of person who co	ompleted cause of death (Item)	280	Print) ()	aleh	ill	awe,	Hage	ms to	2/15	<i>f</i> 2

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

23

2006

32. Registrar's Signature

		,	For State Registrar	State	of Marylar	-	artment <i>rtificate</i>			nd M	ental Hygi	ene	nnc	- A-14	2001
			1. Decedent's Name (First, Middle	, Last)			-				2. Date of Death) from	1110	3. Time o	f Death
	Physici /Medio		Frances Eunice	Fredrick	ζ						Month MAV 1	Day 2.0	Year	6:30	ъм
	Examir		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, T	own, or	Location of	Death	MAY I	4c. Count			E
			Berlin Nursing		Center	c	Ber1					Wor	ceste	r	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthr	place (State	or Foreign
	Director		228-16-0758 Usual Residence of Decedent		84	115.]	1/4/1922	2		VA	
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	Od. Inside C	ity Limits
	Man F	ţ	MD Wor	cester		Ocean P	ines							1 🗆 Yes	2 No
	r 28s	Director	10e. Street and Number	-		,ccan i	10f. Zip C	ode			10	g. Citizen of	What Cour	ntry?	
	ith with the Marylar 23s or 28s-f show	ai	18 Teal Circle				2	2181	1			USA			
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28s-1 show that the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U	J.S. 13.	Was Decede	nt of Hi	spanic Origin n, Mexican, I	n? (Spe	cify Yes or No- Rican, etc.)		ce - Americ		
36	s afte	by Fu	1 Never Married 2 Marri	If Yes, G	2X No ive		1 □ Yes 2		Specify:		,,	Specif			
Ş	72 hours "naturel", odical Ext		3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:	162 Dogg	dent's Usual	000000					WIL	ite	
5.	in 72 ho n "natur Acciral	Completed	(Specify only highes	t grade completed)		(Give	kind of work DO NOT use	done d	uring most o	f workii	ng '	6b. Kind of B	usiness/in	dustry	
s 212	yiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	A	ccount	ing				U.S.	. Ġov	ernmer	ıt.
og ge	be filed tal Hygi d other event,	Be C	17. Father's Name (First, Middle, I	Last)					18. Mother's	Name	(First, Middle, M				
anc		2	William R. Dun	n					Lil1	lian	Walker				
Frances Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	13	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street a	nd Number	or Rura	Route Number,	City or Town	State, Zip	Code)	
_ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	and eaith m 27		Gale Yates								leigh, N	IC 2761	L4		
redrick, Baltimore,	0 0		20a. Method of Disposition 1 △Burial 2 □ Cremation	3 □Removal from		Place of Dispo cemetery, crer			1			Oc. Location	City or To	wn, State	
edri	permit. Pag Depertment Importent: I eny injury o		4 Donation 5 Other (Sp		Gat	e of H		_			_	Dagsbo			
Bale	Deperminent mpo		21. Signature il Funeral Service I	icensee			. Name and		200		he Burba	_		Home	
E4			23a Parti Enter do discordo or	milas	ague ad the dee	th. Do not and	108 MI	.111	am St.	, E	erlin, N	ID 2181	.1		
			23a. Part1. Enter the disease, or shock, or hex rt failure. List of Immediate Cause (Final	only one cars, on	each line.	III. DO NOT GIN				irdiac o	r respiratory arres	SI,		Approximat Interval Bet Onset and	tween
	Physician / /Medical		disease or condition resulting in death)	a. Cer		Euler	145	ciu	and .					Mon	
	Examiner			ATI	(or as a consec	costre	Carrel	ma		0	150000			4	
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec		30.00		in in	10	July 6		-	1	4 5 7
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. <u>D</u>	aboxe	-8-	Me	Mer	ters					70	25°
ó,	cate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to	(or as a consec	quence of):									
8760,	ate b shysic the b	dical		d											
9	The law requires that the death certific Ne has been signed by the attending p page 2 should be detached for use as	/Me	IF FEMALE:	230 Have ou	tcome of pregna								1	-	
Вох	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live I	oirth 2 ☐ Feta nant at time of c	al death 3	Ectopic preg						te of delive nth		Year
P.O.	by the datached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		10au	Other (spec	;iiy)							
	signed by t	by Pr	Part II. Other significant conditio	ns contributing to d	eath but not res	sulting in the ur	nderlying cau	ise give	n in Part I.		23e. Did toba	cco use cont	ribute to th	e cause of d	death?
rds	avire n sign	D D									1 ☐ Yes	2 🗆 No	3 Prob	abiy 4 □l	Jnknown
ဝွ	s been s s been s s should	Completed									24a. Was an	24b. 1	Vere autor	osy findings	available
æ	rsician: The law s certificete has t lirector, page 2 s	E									autopsy	agt?	prior to con death?	noletion of c	ause of
ita		BeC	25. Was case referred to medical			-	-	-	26. Place of	Death	Check only one		I □ Yes	2 No	
>	Physician: this certific al director,	일	examiner? 1 ☐ Yes	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 DOA	Otho			ne 5 ☐ Residen		er (Specify	·)	
2	F Fe F		27. Manner of Death 1. Dendural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	280	. Injury Work			8d. Describe how			,	
sio	death. ctor: A r the fu	cati	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n	ation			М	1 🗆 Y	es 2 🗆 No						
Division of Vital Records,	or At	Certification;	4 Homicide determi	ned 286. Place	of Injury - At he ing, etc. (Specif	ome, farm, stre fy)	et, factory, o	office		2	Bf. Location (Stre City or Town,	et and Numb State)	er or Rurai	Route Num	ber,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician To the	hast of multi-	aniodes 4		the c		lac:					
	Hos 24 h Fun etely	Medical	(Check only one) 2 Medical E	Physician: To the examiner: On the b and man	asis of examina ner stated.	ation and/or inv	estigation, in	my opi	nion, death o	occurre	d at the time, date	se(s) and ma e and place, a	nner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7			29c. l	icense	number		290	I. Date signe	(Month,)	Day, Year)	
			N V DX	Kree	lok	,	K) ~	8,50	> (5/1	7 (56	
			30. Name and address of person v	vho completed caus	se of death (Iten		Print)	_							
ET	10		Victoles Von	solution,	uD.	1209	Cexes	tal	1 Kale	النام	Femile	K Is	land	De 1	9744
1 5	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signa	k A	and I)	1					

			1 - For State Registrar	State of Ma	ıryland				lealth D <i>eath</i>			giene , Reg. No. (2006	17281
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last Lori Ann Gure	ekovich				T		15 4	2. Date of Dea Month	Day,	2004	
j	Examin	ner	4a. Facility Name (If not institution, give Washington County	y Hospital		- A 6-5-46			Location gerst	own	0.0.40	Wa	shingt	on
ľ	Funeral Director		5. Social Security Number 6. Se 164-64-2072 10 Usual Residence of Decedent	M 2 □XF	(In yrs. Ias 26	Yrs.	Months		Hours	Min.	8. Date of Birti (Month, Day Apr 6,	1980	9. Birth	place (State or Foreign intry) PA
	deeth with the Maryland ms 23s or 28s-f show cmust be notified at	tor	10a. State 10b. County PA Frank	lin	10c. City,	Town or Lo	cation ynes	boro						10d. Inside City Limits 1 Yes 2 No
	a with the	Funeral Director	10e. Street and Number 48 W. Main St.	Apt. 3			10f. Zi		172 68	}		10g. Citize	en of What Cou	untry?
0030	be filed within 72 hours after deeth with the Marylan ital Hyglene. Id other than "natural", or Itama 23a or 28a-1 show event, the Madical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 Yes		ispanic Or in, Mexica Specify		ecify Yes or No- Rican, etc.)		t. Race - Amer Black, White Specify: Wh	, etc.
N-C1717	within 72 ho piene. r then "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5- 1	+)	16a. Deced (Give life. I	kind of wo DO NOT u	ork done d ise retired	during mos	_	ng		of Business/li	,
yiana,		To Be C	17. Father's Name (First, Middle, Last) Charles E. Kee						M	ary	(First, Middle, Ann Chi	lcote	2	
е, маг	s 1 and 2 should if Heelth and Mer Item 27 is marke other traumatic		Jason P. Gurekov				W. M	ain		pt.	3, Wayn	esbor	co, PA	17268
altimor	it. Page riment o rient: If		20a. Method of Disposition 1 X Burial 2 Cremation 3 X 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens)	cen	n <i>etery,</i> cren Zior	natory or o	other plac eter	y M	1ay 2	1,2006	Quin	cy, PA	1 Home, Inc
n D	Dermi Depa Impo eny l		23a. Part1. Enter the disease, or comp	1. Moore	ah a daaah		50 S	. Br	oad S	St. W	aynesbo	ro, I	PA 1726	Approximate
8/60,	death certificate be executed e attending physicien and dor use as the burial-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	e. N S a conseque	ance of):		tno						Interval Between Onset and Death 10 ~ 15 Minu
O. Box &	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DUNo 9 ☐ Unknown	23c. If yes, outcome of 1	2 Fetal d	leath 3	Ectopic p		,			23	d. Date of deliv	rery Day Year
rds, r.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions co	ontributing to death bu	it not result	ting in the u	nderlying	cause give	en in Part	1.		bacco use		the cause of death?
al Record	The lar	Completed									24a. Was autop perfor	an sy med? 2 No	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Vital	Physiclen: The this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Inpatier	nt 2∏F	R/Outpatien	it 3 🗆 Di	Oth	05		n <i>(Check only o</i> me 5 ☐ Resid		Other (Speci	6.1
Ion of	Attending Physic death.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		28c. Injun Worl			28d. Describe h			197
DIVISION	를 를 를 드	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc	. (Specify)						City or Tow	m, State)		al Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medicai	one) 2 Medicel Exam	ysician: To the best o iner: On the basis of and manner sta	examination	ledge, death on and/or in	vestigation	n, in my o	pinion, dea	nd place, ath occurr	ed at the time, o	date and p	place, and due t	to the cause(s)
)	viti Con	-	29b. Signature and title of certifier	5.10	ndl	My M	D	c. Licenso $\mathcal{D}_{\mathcal{A}}$	593	36		05	signed (Month,	O G
5F	1-7		30. Name and address of person who o		ath (Item 2	23a) (Type,	Print)	Mic	hae	16.	Radley		10.2	1740
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire	1 . 4	,	,	1		/		

*	,		For State			yland / Dep							0.0	1 70	05
			State RegistrarAmended i 1. Decedent's Name (First, Middle		er dr	/wichd/e	rtificate	of L	Jeath ₍	05-1	9-06/d18 2. Date of Deat	05-12-1	2006	3. Time of De	eath
	Physicia /Medic		Rosetta S. Hob								March	Dav	906	12:20	
	Examin		4a. Fecility Name (If not institution	, give street and n					Location o	f Death		4c. County	of Death		
			Berlin Nursing 5. Social Security Number	& Rehabi		ion Cente			lf Under :	24 Hrs	8. Date of Birth	Wor	rcest		
	Funeral Director		216–16–7969	1 M 2 ½ F	27	32 Yrs.		Days	Hours	Min.	Month, Day,			lace (State or F etry) MD	oreign
	p .		Usuel Residence of Decedent 10a. State 10b. County			Oc. City, Town or L	costice				reo 10,	1,72,4			
	Aaryla f shov	or		'OY		Millsb							'	0d. Inside City I 1 ⊋Yes 2	
	r 28e-	Director	DE Suss	ea.		FILLISIA	10f. Zip	Code			10	Og. Citizen of V	Vhat Cour	ntry?	
	23a o		Rte. 3, Box 193	3				199	966			USA	A		
	er des	Funeral	11. Marital Status	12. Was De Armed I	ecedent Ev Forces? 2 2 No	er in U.S. 13.	Was Deced If Yes, spec	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Sp , Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,		
036	ol', or	þ	1 Never Married 2 Marr 3 ∰Widowed 4 Divorced	tf Yes, C Year or	Give		1 ☐ Yes 2	∑ No	Specify:			Specify	Bla	ck	
2-0	72 ho 'natur	Completed	15. Decedent (Specify only highes	s Education	d)	(Giv	edent's Usua e kind of wor	done a	lurina most	of work	ing	16b. Kind of Bu	ısıness/Ind	dustry	
121	within ena. than	mp	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+)	life.	DO NOT us	e retired, Orer	•			Rest	aura	nt	
ta 1d2	should be filed within 72 hours after death with the Maryland nd Mental Hyglena. I marked other than "naturel", or lleme 23a or 28e-f show umatic event, the Medical Exemples must be collilled at	Be Co	10 17. Father's Name (First, Middle,	Last)						r's Name	e (First, Middle, M				
set	Menta Menta arked artic ev	ToB	Clinton H. Smit	:h					Hatt	ie :	L. Hudso	n			
Rosetta Maryland 21215-0036	12 sho h and 7 is m traum		19a. Informant's Name/Relations	+ 1 27 - 7 - 7							al Route Number,		State, Zip	Code)	
	tend Heelth tem 27 other tr		Mildred Handy/s 20a. Method of Disposition	sister		20b. Place of Disp cemetery, cre	3 BC	X 19 ө of	33, M		boro, DE	19966 20c. Location -	City or To	wn, State	_
sqc uu o	Pages nent of t ant: If Its ary or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		m State	St. Paul				5/16	/2006	Berlin,	MD		
Hobbs, Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiena. Importent: if Item 27 is marked other than "naturel; or Iteme 23a or 28e-f show any injury or other traumatic event, the Mudical Examinar must be notified at once.		21. Signature of Funeral Service	Licenson			2 Name and	Addres	s of Eacility		eral Hom				
	405 # a		23a. Part1. Enter the disease, or	complications that	t caused th	1	618 We	st F	8d., S	Sali	sbury, M	D_21801		Approximate	
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	. /	9 .4				la Di			Onset and Dea	ath
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a	consequence of):	C	cio	(OVE	na	iw pi	xes (1 cer	~ 1
	Examiner	<u>.</u>	Sequentially list conditions,	t. Oue t	0 /01 26 2	consequence of):									
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8760,	cate b physic the b	dicai		d											
Box 6	death certifica attending ph d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o					ı.			23d. Dat	e of delive	inv	3
. B	that the death cer ed by the attendir deteched for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at tir		□Ectopic pre □ Other (spe					Moi		Day Yea	ar
P.0	hat the d by th		9 ☐ Unknown Part II. Other significant condition			not regulting in the	and ach sing or		o in Cost I		230 Did tob	2000 Had and	ibuta ta th	e cause of dear	
Division of Vital Records, P.O.	8 G 9	d by	Farm. Other signmeant condition	and contributing to	Gezar Dat	not resulting to the	andenying ca	use give	mim rani.				3 Prob		known
000	law requir as been si 2 should	piete									24a. Was ar		Vere auto	psy findings ava	ailable
a B	The lay	Completed									autops perform	1 C	death?	noletion of caus 2010o	se of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitals				Otho	. ,	of Deat	Check only one	a)			
to to	Phys or this oral dir): To	1 Yes 2 No	11	Inpatient te of Injury onth, Day			Othe Ic. Injury Work	4 K Nu	-	me 5 Resider			/)	
ö	ath. r: Afte	atio	1 Natural 5 ☐ Pendin ☐ Accident investig	gation	onth, Day Y	(ear) Injury	м		(? /es 2 ☐ I	1		, ,			
N N	l or Atten after deat Director: I in by the	Certification:	3 Suicide 6 Could i 4 Homicide determ	inad 280. Pla	ce of Injury Iding, etc.	/ - At home, farm, s (Specify)	treet, factory	office			28f. Location (Str City or Town,	eet and Number, State)	er or Rura	i Route Number	r,
	Hospital 24 hours a Funeral I letely filled		29a. Certifier	o Physician. To t	he best of	my knowiedye, dea	in occumen	u ine un	ie. date and	d blace.	and due to the ca	use(s) and ma	nner as st	ated	
	To the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	one) Medical	Examiner: On the	basis of eanner state	xamination and/or i	nvestigation,	in my op	oinion, deal	th occur	ed at the time, da	ite and place, a	and due to	the cause(s)	
	To the verbin 2	Σ	29b. Signature and talk of certifie	10			29c	License	number	1	29	d. Date signed	Month,	Day, Year)	
	1 year		30. Name d address of person	who completed as	use of dea	th //tem 23a) /T:	Print	JC	XO1	16	1	210	× (0	6	
	M		Pilling Bon	wito completed ca	Se ui dea	(Type	Con	for	lfu	lau	y Ferry	ctts	dail	PEP	944
	Sta Registr		31. Date filed (Month, Day, Year)	9 2006	Registrar	s Signature	Coast 1								

	•		For State	ite of Maryla	nd / Depa	artment of I	Health and	d Mental Hy	giene	2006	17286
			1. Decedent's Name (First, Middle, Last)	10e&19b pe	r fhye	nuncate of	Deam _{wi}	2. Date of De	ath	6/d1s	3. Time of Death
-	Physici /Medic		Shirley B	\mathcal{H}	art	ing		Month	Day	- O Car	8:10pm
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town,	or Location of De	eath		County of Death	
				At the l	ake		OCCVV	md		J'icom	
h	Funeral Director		5. Social Security Number 6. Sex 158-24-1849		i. last birthday) Yrs.	Months Days		rs. 8. Date of Bir in. (Month, Da 10/11/	1934	Cour	place (State or Foreign htry) Jersey
			Usual Residence of Decedent					10/11/		11CW	oersey
	arylar show	۲	Maryland Wicomico	10c. C	Coling or Lo					1	0d. Inside City Limits 1 ☐ Yes 2⁄☐ No
	the M	Director	- 1		Salisb	10f. Zip Code			10a Citis	zen of What Cour	
	ler deeth with the Marylan Iteme 23a or 28a-f show Iter must be notified at	io is	10e. Street and Number Chumaker D 1101S. <u>Mallard Landi</u>	r. ng Apt. 10	8	1	21804			ISA	wy:
	eme 2	Funeral	11. Marital Status 12. Wa	as Decedent Ever in I	U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No erto Rican, etc.))· 1	14. Race - Americ Black, White.	
36	a o	by Fu	If Y]Yes 2 ∑ No ∕es, Give arorDates:		1 ☐ Yes 2 X No	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify: whi	
21215-0036	n 72 hours "naturel" e Jical Ex		15. Decedent's Education		16a. Dece	dent's Usual Occu	pation		16b. Kir	nd of Business/Inc	dustry
215	d within 7 liene. r then "r	Completed	(Specify only highest grade comp	llege (1-4or 5+)	life.	kind of work done DO NOT use retire	during most or t	working			
22	0 0 = -		12 2 17. Father's Name (First, Middle, Last)		Regis	ster of V		lame (First, Middle		vernment	
lano	od at a	To Be	Robert Hugh Baker					hy Adele		,	
Maryland	2 should and Men le marke aumatic	-	19a. Informant's Name/Relationship (Type, Pr	int)	19b. Mailir	ng Address (Street	and Number or	Rural Boute Numb	er, Cityres	Town, State, Zip	Code)
	s 1 and 2 f Health frem 27 other tra		Donald Harting/husba		110	ol s. Ma l	lard La	ndingapt.	- 108	, Salisb	oury,MD2180
Jore	o to to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	ai iioiii State		sition (Name of matory or other pla	1	Date		cation - City or To	
Baltimore,	교통론을 .		4 Donation 5 Other (Specify) 21. Specifical Service Library	Λ Si		y Cremat		/17/06		isbury, l	
ä	permit. Depertr Imports eny inje		y on Hall	Me	5	Ol Snow	Funeral Hill Rd	Home Pro Salisb	tess: ury,	ional As MD 2180	sociation 4
			23a Parti. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused # e d see on each if e.	th. Do not ent	er the mode of dyi	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	etastat	The L	runs	Cun	cel			Onset and Death
	Examiner			Due to (or as a conse	quence of):	0					
	n i	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listeds of thur) that initiated events c	Due to (or as a conse	quence of):						
	ecuted and -transi	Examiner		Due to (or as a conse			/				
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		ledicai	0								cent.
Вох	eath certifi ettending for use as	an/N		res, outcome of pregr]Live birth 2 ☐ Fet		Ectopic pregnanc	y		2	3d. Date of delive	
0	The law requires that the death certi te has been signed by the ettending tage 2 should be delached for use a	Physician/M	1 Yes 2 No	□Pregnant at time of □Unknown	death 5□	Other (specify)	·			Month	Day Year
0	es that igned by	by Ph	Part II. Other significant conditions contributi	ng to death but not re	sulting in the u	nderlying cause gr	en in Part f.	23e. Did t	obacco us	se contribute to th	e cause of death?
of Vital Records,	w require been sig should b							_ >	Yes 2	No 3□Prob	ably 4 Unknown
Sec	e law re has be je 2 sho	Completed						24a. Was	psy	prior to cor	osy findings available impletion of cause of
alF		e Cor	25. Was case referred to medical					1 ☐ Yes	No No	death? 1 ☐ Yes	2210
ž	Physiclan: this certifice ral director, p	o B	examiner? 1 Yes 2 No Hospita	I: 1 Apatient 2	☐ ER/Outpatien	t 3 DOA Off		eath <i>Check</i> on √ o Home 5 ☐ Resi			4
	ding Ph h. After thi funeral	on: T	27. Manner of Death 28a	Date of Injury (Month, Day Year)	28b. Time of			28d. Describe			7
Division	Attending r death. ector: After by the fune	cati	2 Accident investigation			M 1	Yes 2 □No		·		
Div	of or Attence of the death of the Coor.	Certification:	4 Homicide determined 286	 Place of Injury - At I building, etc. (Spec 	nome, farm, str lify)	eet, factory, office		281. Location (City or To	Street and wn, State)	l Number or Rura	l Route Number,
	To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the		29a. Certifier Cartifying Physician: (Check only Medical Examiner: O	To the best of my kn	iowiedga daut	Conumet at the ti	ne, date and pla	ine, and due to the	causa(s)	and marner as st	Med.
_	To the H within 24 To the F complete	Medical		nd manner stated.	ation and/or in			curred at the time,			
	F ₹ F 8		14)15/1	///M	0	29c. Licens		78		signed (Month, I	
	Com.		30. Name and address of person who complete	ed came of death (Ite	om 23a) (Type,	Print)	110 -	0		10	
	7		David Creat, NOW	Coestal H		po lo	10×173	78 3 Seels	sh,	MD ?	1802
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 2006	32. Registrar's Sign	iacure	ask .		_	Š		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month CHARLES NORDHOFF HYATT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG. 25, 19 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. Director 579-34-9405 76 1929 WASHINGTON. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23s or 28e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23s or 28e-f show Evantiner must be notified at Be Completed by Funeral Director 1X Yes 2 No DELAWARE SUSSEX OCEAN VIEW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 NAOMI DRIVE 19970 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xyes 2 □ No If Yes, Give Year or Dates: KOREAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced other treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN GREETING CARDS 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **VESTA** HYATT MARTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANITA O. HYATT/WIFE 118 NAOMI DRIVE, OCEAN VIEW, DELAWARE 19970 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) MARINER'S BETHEL CEM. 5/19/06 OCEAN VIEW, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DNUMONIZ day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending Division 1 Natural 5 Pending 24 hours after death, Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The defining Physician: (o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mathrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 205ect 32. Pagistrar's Signature Registrar MAY 18 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month EVELYN LEE HATCHER May 2006 2:05 p. M 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 507 Main Street Myersville Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F Director 228-74-5528 82 Yrs Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir then "naturel", or Items 23a or 28a-f shov the Medical Examinat must be retified at 1 Yes 2 □ No Director Maryland Frederick Myersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 507 Main Street 21773 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ∆ Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be 1 Mental I George Etchison Baker Reba Marguerite Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 is i James M. Hatcher/son 507 Main Street, Myersville, MD 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Itel
any Injury or otl
once. ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6-1-2006 Lovettsville, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Enter the isease, of Americations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METATTATIC COLON CANCEL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under vin. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transit attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 🗌 Yes No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 Tes Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 24 hours after death. 5 Pending To the Hospitel or Attendir within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 Tes 2 No ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 131761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 0' 2/70/ BRIAN CONNOR MA 501 W. SEVENTA 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

06-03483 Please Type or Print in Black Indelible Ink John A. Hartman State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 22, 2006 1601 hrs Medical Examiner John Adam Hartman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany 445 Dirk Avenue Cumberland 5. Social Security Number 6 Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Months Days Hours Director 6-1-1946 235-70-3079 59 Country) WV 1 X M 2 F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No 28a-f show or items 23a or 28a-f shormust be notified at once. MD Allegany Cumberland rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country ö 21502 USA 445 Dirk Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? White etc. Never Married 2 X Married Yes 2 X No Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify. Specify white "natural", ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than umatic event, the Medical MD 21215-0036 Finan Center Laborer 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) marked Be Margaret Hartman Guy Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1004; Cumberland, MD 21502 Susan Hartman/wife Pages | and 2: ment of Health a tant: If item 27 or other traum 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: Scarpelli Funeral Home 5/24/2006 Cresaptown, MD Donation 5 Other Specify 22. Name and Address of Facility Scarpelli Funeral Home, 21 Signalure of Funeral Service 108 Virginia Avenue, Cumberland, MD 21502 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart It I. Enter the disease, or co ture. List only one cause on Approximate Interval **Physician** Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED · burial · of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other. Scene 1 V Yes 27. Manner of Death 28a. Date of Injury FOUND: Pay, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot FOUND Natural Division Yes 2 V No Pending May 22, 2006 1601 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 445 Dirk Avenue, Cumberland, MD within 24 hours a To the Funeral I determined (Specify) Single Family Home 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b of certifier 29d Date signed (Month, Day, Year) O.C.M.E May 23, 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assi

Assistant Medical Examiner

Registrar's Spnature

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	Physici /Medic		Decedent's Name (First, Middle, Last Mat		hlor	is Ham					2. Date of Do Month May	Day 24	2006	3. Time o	f Death
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Maryland 21215-0036	nd 2 should be filed within 72 hours eiter death with the Marylend lith and Mental Hygiene. 27 is merked other then "natural", or Itame 23a or 28a-f show r treumatic evant, it e Madical Examinar must be notified at	To Be Completed by Funeral Director	Maryland Cecil 10e. Street and Number 3120 Telegraph II 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grace Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) Norris Ford 19a. Informant's Name/Relationship (T. Paul F. Hamm/Net	12. Was Dec Armed F. 1 ☐ Yes If Yes, Gi Year or D (cation College (edent Evo proes? 2 No ve A	16a. D	n 10f. Zip	921 Jent of History Cubar Stranger of History Cubar Stranger of History Cubar Al Occupant done of the retired of the Press (Street a	Specify: ation furing most sentat 18. Mothe Ethe	t of worki	ing ə (First, Middle al Route Numb	Un o- 14 S 16b. Kind Co o, Maiden S	Black, White Black	ountry? States erican Indian, ite, etc. White s/Industry CS	2 X No
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Division of Vital	tending Physicien: leath. tor: After this certifice the funeral director, t	Certification; To Be C	25. Was case referred to medical examiner? 1	28a. Date (Mon	th, Day Y	'ear) 28b. Tim Inju	ne of 2	8c. Injury Work	T. 18	rsing Ho	me 5 Resi	idence 6 (□Other (Spe		ber,
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	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 1 2006	2. M.S. F	Registrar's	th (Item 23a) (Ty	LONIA	L V	vay	, R	15175	JMM	INU	2199	

		•	For Amend Items	State of 23b, 25	of Marylar per ME,	G855-0	artment of 5/30/06d	lealth a hb <i>Death</i>	and Mental Hy	giene Reg. No:-	006	17291
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	/Medic Examin	100	4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town,	or Location of			ounty of Death	
	LAdilliii	C.	Fox Chase Rehab	& Nursi	ng Cent	er	Silver	Sprin	ıg	Мо	ntgome	ry
-	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8. Date of Bir	th av. Year)	9. Birth	place (State or Foreign
	Director		242-16-2896	1 □ M 2 (□ F	72	Yrs.			Min. (Month, Da May 16	, 1933	Durh	am, N.C.
	and **	}	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
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0	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or lieme 23a or 28a-f show avent, the Medical Examinar must be notified at avent, the Medical Examinar must be notified at	ø	17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Name (First, Middle	, Maiden Su	ımame)	
land		To B	Isaac Perkins					Eliz	zabeth Perk	ins		
Mar)	ges 1 and 2 should be t of Health and Mental If item 27 le marked or other traumatic av		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	t and Numbe	er or Rural Route Numb	er, City or T	own, State, Zij	Code)
≥ ~	0 S N 5		Mary Louise Po	erkins	005			ve. #3	BH Brooklyn			
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g	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service L	licerisee /	1				., N.W. Was			
			23a. Parly Ent the Signal or show, or heart failer List of	complications that	cause I III dea	-		•	cardiac or respiratory a			Approximate
	A Company		Imm of the Cause (Final	only one suse on	each line.	M	RIBER	\ \ / /	•			Interval Between Onset and Death
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×	death certifica e attending ph id for use as t	cian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	itcome of pregn	ancy		CERTIFIC		23d	I. Date of deliv	erv
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	or Attending Physician: after death. Director: After this certific in by the funeral director.	ifica	3 Suicide 6 Could n	ned 286. Plac	e of Injury - At I	nome, farm, str	reet, factory, office				lumber or Run	al Route Number,
בֿ	tal or is after sel Dir	Certification:	4 - Homicide	Dulk	ding, etc. (Speci	(iy)			City or To	wii, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(CHECK ONLY 2 Medical I	g Physician: To the	e best of my kn	owledge, deat	h occurred at the to	ime, date an	d place, and due to the	cause(s) and date and nis	d manner as s	stated.
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	To To		29b. Signature and title of certifier	MAGAN	AllA		A C	7717			igned <i>(Month,</i> - ひってん	D, UDb,
	0		30 Name and address of access	who completed as:	see of door to	m 23a\ /T	Print)	7000	ANDWOOD	Cal. No in	7 0	-, 400,
-	3		30. Name and address of person	MD: 2	(M. A. Z.	iii zsa) (Type,	-min 34	11, DI	MUNINUN	LOVA	תוער, ו	E - 105
- 2	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature						
	Registi		MAY 3 0 20	06 Blace	الله مع	Marke	***					

		•	For State Registrar	State of Maryland		irtment of H			giene Reg. NG 006	17292
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Yea	3. Time of Death
	Physici /Medic		Barry	W. Haley				May 10		1656 M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	,		4c. County of D	eath
6-	*.	e de	6906 Forbes	Boulevard			If Under 24 H		Fince	6 eorge's
	Funeral		5. Social Security Number 6. Sex 128	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours M		y, Year) 9.	Birthplace (State or Foreign Country)
23	Director		Usual Residence of Decedent	09				April 3	,1937 1	llinois
	/land		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Many	ţċ	Md. Prince Ge	orge's Sea	brook					1 Yes 2 XNo
	or 28,	lie	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	ai	6906 Forbes B1	vd.		20706			U.S.A.	
	teme teme	by Funeral Director	11. Walta Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hi I Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	- 14. Race - A Black, W	merican Indian, /hite, etc.
36	s afte	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔂 No If Yes, Give Year or Dates:		I ☐ Yes 2🌇 No	Specify:		Specify:	Black
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow Jisal Examinat ha Indiffed al	edt	15. Decedent's Edu		16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busine	ess/Industry
15	in 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed)	(Give life. l	kind of work done o DO NOT use retired	during most of i ()	vorking		
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Man	ager-Cons	sultant		Fed. Go	vernment
b	al Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumame)	
<u>la</u>	Ment Ment arked	2	Wallace Haley				Sus			
Maryland	and and second		19a. Informant's Name/Relationship (Ty			,			эr, City or Town, Stat	,
2	and fealth im 27 her ti		Waunita Haley (Dau			E. Republ	Lic St.	Peoria, 1	11inois 6	
0	P its	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	netery, crer	natory or other plac	1			
Baltimore,	rtmer rtant njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Crematory			Riverdal	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Iteme 23a or 28a-f show many injury or other traumatic event, the Madical Examiner must be indifficial an ance.		homas 5	horalu	- Ch	ambers Fi	ineral	Home + Cr	ematorium ale, Md. 2	,P.A. 20737
			23a. Part1. Enter the disease, or compl	cations that caused the death.						Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	Auteriosy	+	/4 -	of the	in H	east Di	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):	ic hyp.	Shi -ch	200-11		3 45.2
	Examiner		the state of the s							
		ner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):					
	nd transi	Examiner	that initiated events	2. <u> </u>						
50,	oe exe cian a curial-	Ä	resulting in death) Last	Due to (or as a conseque	ince of):					
8760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		J						
9 X	ding	/Med	IF FEMALE:	3c. If yes, outcome of pregnant	cv		2.00		23d. Date of	delivery
Вох	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	the d y the sched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
σ.	that ned b	by Pt	Part II. Other significent conditions con	ntributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
rds	w require: been sig should b	pe pe						101	Yes 2 ☐ No 3 ☐	Probably 4 Hinknown
ecords,	aw re s bee 2 sho	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
α	0 2 0	E		1100-1-0				perfo	rmed? deatl	n?
ital	icien: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?				26. Place of I	Death (Check only o	nne)	
of Vital	ding Physicien: h. After this certific funeral director,	2	1 ☐ Yes 2 ☐ No		R/Outpatier		4 14015111		dence 6 Other (5	Specify)
n c	E	Ë	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Worl		28d. Describe h	how injury occurred	
Sio	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	CO. Diversities Ash	4		Yes 2 □ No	29f Location /	Street and Number o	r Rural Route Number.
Division	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, tarm, str	eet, factory, office		City or Tov		r Hurai Houte Number,
	ours sours sours sours sours sours sours filled	0	29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my know	ledge, deat	n occurred at the tim	ne, date and ol	ace, and due to the	cause(s) and manne	r as stated.
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Medical		ner: On the basis of examination and manner stated.						
	within To th	Me	29b. Signature and title of certifier	C2 57 124		29c. License			29d. Date signed (M	
	16		Labordo	Master Do		No	0559	27	Mary 16,	2006
_	7		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type,	Print)		/		
			SALVAdor Sylva		Espi.	tal Dri.	ve, Co	toverly	Mary 16,	1 and
	St. Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	ire An	and I	,	VP.		
no.	- Incaior		(41) 4.1 ···· (/.1)	UU 17 1 23	Tu p	_				

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Laura Orintha Hull 2006 May 19. 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Washington Williamsport 8. Date of Birth (Month, Day, Year) Nov. 19, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 220-18-0947 Director 1924 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location worle 10d. Inside City Limits ir then "natural", or itema 23e or 28a-f ehov tre Madical Examiner must be notified at 1 ☐ Yes 2 🕅 No Washington Hagerstown Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10836 Oak Valley Drive 21740 USA Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary i. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tent: if Item 27 Is marked other th jury or other traumatic event, Ins 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Hillyard Rash Charles Page Shirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane A. Stone - Daughter 350 Winding Oak Drive Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-22-2006 Clear Spring, Maryland St.Paul's Cemetery 21. Sign were of Funeral Service Li 22. Name and Address of Facility Osborne Funeral Home, P.A. Williamsport, MD 21795 425 S. Conococheague St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final wat **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificete has t irector, page 2 s autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) မှ this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by determined 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) 424 Opro 32. Registrar's Signature ZY DELOS 5H-7 Year State Registrar

			For State Registrar	State of Maryland /	-	ment of He ficate of D			ene 200	6 17294
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Isaac Rowland	Herbert				Date of Death Month M & U	Day Yes	i / (/ * 7 / M
<u>ز</u>	Examin	er	4a. Facility Name (If not institution, give str Washington Cou 5. Social Security Number 6. Sex	nty Hospital	L birthday)!	b. City, Town, or L Hagers f Under 1 Year flonths Days	town,		4c. County of D Washi	eath
	Director		213-68-6953 1 21 Usual Residence of Decedent 10a. State 10b. County	1 2 ☐ F 6 Z 10c. City, To	Yrs. Nown or Locat		Hours Wiff.	Date of Birth (Month, Day, May, 4,	1944	10d. Inside City Limits
	the Maryli r 28a-f sho noulled a	Director	MD Washingt	on Hage	ersto	10f. Zip Code		10	g. Citizen of What	1 ☐ Yes 2 💆 No Country?
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23e or 28e-f show myn njury or other traumatic event, Ite Medical Examinar must be notified at ances.	Funeral D	1 XNever Married 2 ☐ Married	AVE . . Was Decedent Ever in U.S. Armed Forces? 1Yes_ 2 No If Yes, Give			opanic Origin? (Spec , Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	Black, W	merican Indian,
Maryland 21215-0036	vithin 72 hours ne. han "natural", ne Medical Exa	Completed by Funeral	15. Decedent's Educa (Specify only highest grade of Elementary Secondary (0-12)	Year or Dates:	6a. Deceden (Give kin life. DO	t's Usual Occupat		7	6b. Kind of Busine	ss/Industry
and 5	ld be filed v ental Hygie kad other t fc event, th	To Be Co	2nd grade 17. Father's Name (First, Middle, Last) Earl William H	erbert		1	18. Mother's Name (
	and 2 shou saith and M n 27 is mar		19a. Informant's Name/Relationship (Type Betty Dodson s	ister	123	Massie	Lane Ste	ephen	City, V	A 22655
Baltimore,	Pages 1 tment of He tant: if Iten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State St. I	Paul	ory or other place; Cemeter	У 200)5		pring, MD
Ba	Departiment of the popular in the po		21. Signature of Funeral Service Licensee	o Pauley Ja	P.	0.BOX 3	10 Clear	Spri	ng, MD	
)	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) a. Saguration list condition, if any, leading to immediate	Ather oscler of: Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent)	ce of):		such as cardiac or		st,	Approximate Interval Between Onset and Death
68760,	ificate be executed physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):					
P.O. Box (Attending Physician: The law requires that the death certif r death. sctor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dec 4□Pregnant at time of death 9□Unknown	ath 3 ⊟Eo	etopic pregnancy ther (specify)		· · · · · · · · · · · · · · · · · · ·	23d. Date of Month	delivery Day Year
	equires tha een signed hould be det	δ	Part II. Other significant conditions control Mentally Retaco		ig in the unde	erlying cause giver	n in Part I.	23e. Did tob	1/	e to the cause of death? Probably 4 □Unknown
Division of Vital Records,	hysicfan: The law i his certificate has b I director, page 2 st	Completed						<u> </u>	ed? prior death	autopsy findings available to completion of cause of ?? es 2 No
f Vit	ysicfar iis certif directo	To Be	25. Was case referred to medical examiner? Yes 2 \(\text{No} \) No	spital: 1 ☐ Inpatient 2★ ER/	/Outpatient	3□ DOA Other	26. Place of Death (4 ☐ Nursing Home		nce 6 Other (S	(pecify)
sion o	ttending Phy death. ctor: After this y the funeral of	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	b. Time of Injury		es 2 🗆 No		w injury occurred	
Divi	To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town,	State)	Rural Route Number,
	To the Hos within 24 hd	ledical	(Check only Medical Examine one)	r: On the basis of examination and manner stated.	and/or inves	tigation, in my opi	nion, death occurred	at the time, da	te and place, and o	due to the cause(s)
	To To	Σ	29b. Signature and jitle of certifier	ty Midical Exc	7	29c. License			d. Date signed (Mo	
7	14-3		30. Name and address of person who com	plied cause of death (Item 23	la) (Type, Pri	nt) +: e+	Stroct	Hages	town, m	7.2006 21740
5	Sta Regist	ate rar	31. Date filed (Month) Day Nearly 20	32. Registrar's Signature	. Sol	the		3		

		•	For State Registrar	State of Maryl		artment of H rtificate of L		1115.1	ene 006	17295
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Jacklyn Woolford					2. Date of Death	Pay 2006	3. Time of Death 9:30 a M
	Examin		4a. Facility Name (If not institution, give s 3985 Germantown R			4b. City, Town, or Edgewate	Location of Death	,	4c. County of Death	
	Funeral Director		5. Social Security Number 219-40-6697 6. Sex	7. Age (In M 2 X F 64	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 7,	1941 9. Birth Cor Mar	place (State or Foreign intry) y Land
	he Maryland 8a-f show	ector	Usual Residence of Decedent		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 2	Dir	10e. Street and Number 3985 Germantown R	oad		10f. Zip Code 21037		1	og. Citizen of What Cou United Sta t	•
980	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exercitar must be notified at	by Funeral Director	11. Marital Status 1 Never Married A Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ Who	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
21215-0036	within 72 ho iene. then "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired T	luring most of work	ring	6b. Kind of Business/l Funeral Hor	
Maryland 2	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Me.	To Be C	17. Father's Name (First, Middle, Last) Jethro Timothy Wo	olford			18. Mother's Name Evelyn	e (First, Middle, M Jane Fost	,	
	s 1 and 2 should t Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Thomas A. Hardest						city or Town, State, Z	
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other plac Cemetery	e)		Oc. Location - City or Talesville	
Balt	permit. Departr Importa any inje		21. Signatury of Funeral Service License	Moven	1	2 Ridgely	Avenue A	Annapoli:	uneral Home s, Maryland	-
8760,	Physician /Medical Examiner e pe executed e prival-Itansit	dicai Examiner	23a. Par . Inter the disease, or comp so or or heart failure. List only of medical cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	sequence of):	ancer	g 54501 45 64 54 54	or respiratory and		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
	w requires that the bear signed by should be detac	þ	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	
Il Records,	iician: The law requ certificate hes been rector, page 2 shoul	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Vita	sician: certific rector	Be	25. Was case referred to medical examiner?	lospital:	- 57 50 10	2 DOA Othe		h Check only one		
Division of Vital	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate he completely tilled in by the funeral director, page	ation: To	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Injun	4 Nursing no	28d. Describe hor	nce 6 Other (Spec w injury occurred	ıfy)
Divis	To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A completely tilled in by the to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str oecify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospital within 24 hours e To the Funeral I completely tilled	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exa- and manner stated.	knowledge, deatl mination and/or in	n occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	in o		29c. License	number		d. Date signed (Month	,
,			30. Name and address of person who con Jeanne Weiner	empleted cause of death			0030		May 15,20) (o
	Sta Regist		31. Date filed (Month, Day, Year)	6 2006	7	d Esos	may	SIIS , MA	190	1

		1 - For State Registrar	State of Marylan	d / Depa		lealth and M	ental Hyg			172	96
		Decedent's Name (First, Middle, La	st)		initiate of t	Jean	2. Date of Deat		700	3. Time of	Death
Phys		JOHN	PAUL HES	S			Month May	1 day	2 ^Y 8°06	4:26	
	dical niner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. Cou	nty of Death		
- 33 - 3		Frederick Mem	orial Hospit	al	Frede	rick		Fr	ederi	ck	
Funer		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar.	Year)	Count	ace (State or	Foreign
Directo	or	562-36-1446 Usual Residence of Decedent	73	Yrs.			Mar. 2	29, 1	933	LA	
land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10	d. Inside Cit	y Limits
Many	to	MD Fred	erick	Mic	ld1etown					1 XYes	2 🗍 No
th the	le o	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Count	ry?	
1215-0036 within 72 hours after death with the Maryland ane. than "natural", or iteme 23a or 28a-f ahow in Medical Examinar must be notified at	by Funeral Director	3306 Matzen C	t.		217			U	SA		
er des	Tue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 0 5	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto I	ecify Yes or No- Rican, etc.)		lace - America llack, White, e		
36 s afte	F.	1 Never Married 3€ Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No 195 ff Yes, Give Year or Dates: 197	0-	1 ☐ Yes 2👿 No	Specify:		Spe	cify: Whi	t o	
-00 hour	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of	Business/Ind		
215 7 nin 72 Media	plet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) Coflege (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of workii	ng			,	
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yla ouid t Ment Ment Ment Ment Ment Ment Ment Men	2	Steve Ca				Eugenia					
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. stem 27 is marked other than "natural", or itame 23s or 28s-f show other treumatic avant, the Medical Examples must be notified at		19a. Informant's Name/Relationship (Patricia Hess				Ct., Mi					
Baltimore, Moemit. Pages 1 and 2 Department of Health Moortant: If item 27 in yinjury or other tre		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	e) D	ate	20c. Locatio	n - City or Tov	vn, State	
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\mathcal{E}_{t}		28a Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arre	est,		Approximate Interval Betw	reen
Physicia		Immediate Cause (Final disease or condition	BICA;	TERF	94 /	PNEUN	10111	9		Onset and D プタン_	
/Medica		resulting in death)	Due to (or as a conseq	uence of):							
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.O. Box the death cer y the attendin tched for use	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of do		Other (specify)			'	Month [Day Y	ear
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Vision of Vita Attending Physicien: r death. ector: After this certific by the funeral director.	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	ot 3 DOA Othe	26. Place of Death			ther (Second)		
og Phy ter this		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury	at 2	28d. Describe ho				
ion inding ath. r: After ie funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		Injury	M 1 🗆 Y	Yes 2 □No					
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Di To the Hospitel or within 24 hours afte To the Funerel Dii completely filled in	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my kno miner: On the basis of examina	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ed at the time, da	iuse(s) and ate and plac	manner as sta e, and due to t	ted. he cause(s)	
ithin S than	Med	29b. Signature and title of certifier	and manner stated.		29c. License				ned (Month, D		
₽ ¥ ₽ 8		· // /	1 MD								-
Avr. D.		30. Name and address of person who	completed cause of death (Iten	23a) (Tyne		61410					
12411		LAFFAR	SYED 8	01 7	TOLL H	OUSE	AVENU	E, F	REDE	RICK	, MD
1000 PM	State istrar	30. Name and address of person who AFFAR 31. Date filed (Month, Day, Year)	2006 32. Rigistrar's Signa	ture A	pade						

Amondod dtes		State of Maryland / Department of Health and Me 1- State Registrar #31, per DVR, 5/19/06, E. Fertificate of Death WCHD		ne 006	17298
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Physic /Med	lical	Aileen M Jarvis. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	05	16 2006 4c. County of Deat	9
Exam	iner	Atlantic General Hospital Berlin		Worceste	
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Y. 9/22/191		hplace (State or Foreign untry)
Directo	_		9/22/191	1	MD
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland -f show	tor	MD Worcester Ocean City			1 ZYes 2 ☐ No
19 LI	Funeral Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
19 19 19 19 19 19 19 19 19 19 19 19 19 1	ral D	300 N. 6th St. 21842		USA	
Ser dez	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Polymer) If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
Co. 4 (32) 19 15-0036 n 72 hours after death with the Marylan "neturel", or tems 23a or 28a-1 show safest Examinat must be notified at	by F	1 □ NSever Married 2 □ Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: W	hite
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and 2 seatth a m 27 le		Renee Green 602 Edgewater Ave., Oc	cean Cit	y, MD 218	42
D.O. Studoc D. Baltimore, Maryland 212. Popartimore, Maryland 212. Popartiment of Health and Mania Hygiene. Important: If Item 27 16 marked other than any injury or other treumatic event, tream		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or	
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× 1		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest	,	Approximate Interval Between
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Geath death ed for ed for	sicia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		Month	Day Year
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F Vital F vsician: The scorrificate director, pag	BeC	25. Was case referred to medical examiner?			
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Did rs after rs after bir led in	Cert	Fullulity, etc. (Specify)	Only or Town, c	Jiato)	
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Vertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the caus d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier 29c. License number	and the same of th	. Date signed (Mont	n, Day, Year)
		1 M65+2 MD D0061325		13/16/	7006
ET 6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manesh Patel Atlante General Hoppth 9733 Health	Gway 1	Drive, De	lin,40 21811.
Regi	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 9 2006	K ha	A	
DHMH 17 Rev	₹ _A	-03 (18/00)	- 190	-06-	

ORIGINAL

James W. Jackson, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certi	ificate of	Death		F	Reg No.	201	16 1/29	
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	T			Date of De Month	Day	Year	3. Time of Death		
edical Examii		James W. Jackson,			0 To 10 001	Leasting of Booth	May 12, 2		125	0859 hrs	
		4a. Facility Name (if not institution, give str Anne Arundel Medical Center		1	b. City, Town, or I Annapolis	Location of Deati	1		County of Dear ine Arunde		
Funeral	4	Social Security Number	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of B			irthplace (State or	
Director	Ì	210 05 1020	2_F 84	Yrs.	Months Days	Hours Min	May 1	8. 19	Pore C	ountry) Virginia	
	-	Usual Residence of Decedent				-l					
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nd show	ᅵ	Maryland Anne Arur	nde1		Ar	napolis				1 XYes 2 No	
faryla 28a-f	Director	10e. Street and Number			10f. Zip Code				n of What Co		
a the Na or		925 Windsor Avenue			2	21403			U.S.A.		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?		s Decedent of His es, specify Cuban			0- 1-	Race - Ame White, etc.	erican Indian, 8lack,	
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36 thin 7 re. than edica	힏	12		Planne	er and Es	stimator	or Federal Government				
5-0(ed wi tygie other	S	17. Father's Name (First, Middle, Last)					lame (First, Middle, Maiden Surname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	Wilbur Jackson					(unkno				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I and: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	ပ္	19a. Informant's Name/Relationship (Type Eleanor Jackson/wi			Address (Street						
MD and 2 sho salth and em 27 is raumati		20a. Method of Disposition			ition (Name of cen		Annapolis, Maryland 21403 Date 20c. Location - City or Town, State				
Ore of He If it		1 XXBurial 2 Cremation 3	Removal from State cre	ematory or oth	ner place)						
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Physician			omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre						k, or heart	Approximate Interval	
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Division of Vital Records, tal or Attending Physician: The law requiring Physician: The law requiring a star cetain all Director. After this certificate has been sited in by the funeral director, page 2 should t		4 🗆 1111	May 12, 2006 on the pending Ma								
Sio	Cati	2 🗸 Accident Investigation	t Investigation 8 Could get be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Num							Rural Route Number, City	
Division pital or Attene ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	(Specify) Local Stree		,,		or Town	State)		son Street, Annapoli	
Hospi 4 hou Funer ely fil		20a Codifier	To the best of my knowledge		rred at the time, da	ate and place, an		•			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate death within 24 hours after death The Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) 2 Medical Examiner: 0	n the basis of examination an								
F W F O	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	ate signed (M	fonth, Day, Year)	
		Upywie mels	hell		O.C.I	M.E.		May	14, 2006		
		30. Name and address of person who con						-			
			stant Medical Examine		enn Street, B	altimore, MD	21201				
	State 31. Date filed (Month, Day, Year) Registrar MAY 1 6 2006 32. Registrar's Signature.										
Regis	TIC.	111111 20 20	- Charles								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-State Registrar Amend #8 Per FH G856 6/967/1008/1979 Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician SHIRLEY MARTHA KREBS 2005 27 5:26 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 60 Fairground Avenue Taneytown Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 10, 10) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Mary Land **Funeral** Months 1 ☐ M 2 🖾 F 47 218-72-4289 Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at Maryland Carroll 1 TyYes 2 □ No Director Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Fairground Avenue 21787 USA or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene. Item 27 le marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carroll Leo Porter Madeline Stem ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Krebs/spouse 60 Fairground Ave., Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 29 permit. Pages 1 Depertment of H Important: If Ite eny Injury or ot ong Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory Smithsburg, MD 2006 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Futheral Service Licensee M00534 vhull Stills 136 E. Baltimore St., Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Metaste Immediate Cause (Final disease or condition resulting in death) Opset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 46 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 2 filled in by the funeral dir 1 Inpatient this 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check one) 1 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year)

1

State

Registrar

30. Name

FLAV 10

31. Date filed (Month, Day, Year)

JUN 0 1 2006

Division of Vital Records, P.O. Box 68760,

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S. GEN

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32 Registrar's Signature

WESTMINSFER MD

and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene State Registra MEND#28a-fperME, 5/17/06, EMN, McCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2006 **Physician** May 12, RUSSELL AUSTIN KIDWELL 5:31 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9925 Harmony Lane Laurel Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 18, 1980 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2□ F Mary Tand 26 220-94-2725 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Laurel 1 Yes 2 No Maryland Howard Director 10g. Citizen of What Country? United States 10e. Street and Number 9925 Harmony Lane 10f Zin Code 20723 Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 naturel', or Specify If Yes, Give Year or Dates: 2 3 ☐ Widowed 4 ☐ Divorced er than "nature Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Transportation Safety Administration College (1-40(5+) Elementary/Secondary (0-12) al Hygiene. National Airport Baggage Screener 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny liquy or other traumatic event potes. Be Kidwell Katherine Badger Roger F. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roger F. Kidwell -father 4216 Ulster Road Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/13/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licens 12/20/20 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Immediate Cause (Final disease or condition resulting in death) Environmental Asphyxia due to Inhalation of Car Exhaust **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No Certification: To this hours after death. Ineref Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2√2 No Subject inhaled exaust fumes Found 5/12/06 $5:31p^{M}$ 2 Accident
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 9925 Harmony Lane; Laurel, MD at home 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely Within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1160291 D08949 May 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bert F. Morton, MD 2802 Montclair Ave. Ellicott City, Md. 21043 32. Pégistrar's Signature 31. Date filed (Month, Day, Year) 17 2006 Registrar

		1 - State Registrer	State of Maryland	,		Health and I	R	eg. No.	106	17302
Physic		Decedent's Name (First, Middle, Last) Shirley		KING			2. Date of Dea Month May 16	Day	Year	3. Time of Death 6:08 A M
/Med Exam		4a. Facility Name (If not institution, give str Washington Adventis			•	n, or Location of Death	h		y of Death	У
Funera Directo		5. Social Security Number 6. Sex	7. Age (In yrs. la X 84	st birthday) Yrs.	If Under 1 Ye		8. Date of Birth Month, Day Oct. 15,	1921	9. Birthp	lace (State or Foreign
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ĕ = 5	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		/as Decedent Yes, specify (of Hispanic Origin? (Stuban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)		ice - Americ ack, White, ify: Wh:	etc.
within 72 hours af ene. then "natural", or	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give k life. D	ent's Usual Oci and of work do O NOT use re	ne during most of wor tired)	rking	16b. Kind of Prince Polic	Georg	ges County
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nd 2 shoullth and M 27 Is mar	-	19a. Informant's Name/Relationship (Typ Norman King / son	e, Print)	19b. Mailing 12302	Address (Sta	eet and Number or Ru 1 Drive, C	ural Route Numbe Saithersb	r. City or Town	n, State, Zip D 208	Code) 78
bermit. Pages 1 av Depertment of Hea mportant: if item any injury or othe	3	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	l ce	ace of Dispos metery, crem lean Me	atom or other	olace) Garden May	Date 7 17,2006	20c. Location 01ney	-	wn, State
permit. Depertri Importa	300	21. Signature of Fundral Syrvice Libense	3-zlar	25	54 Carr	oll St., N	W, Washi	ngton,		
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requires that been signed should be de	Completed by Pt	Part II. Other significent conditions conf	nibuting to death but not resu	alting in the un	derlying cause	given in Part I.	1 □ Y	es 2□No an 24b	3 □ Prob	psy findings available
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To the Hospital or within 24 hours affect To the Funeral Dir.	edical C		ician: To the best of my known or: On the basis of examinat and manner stated.							
To the To the Complete complete	Me		TENDING	M 5	· P6	ense number	m	29d. Date sign	ed (Month,	2006 vnue
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State of Maryland / Department of Health and Mental Hygiene [] [] [

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			Registrar		Ce	rtificate of l	Death	R	eg. No,		
	1-3	ÿ	1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat			3. Time of Death
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	/Medic		4a. Facility Name (If not institution, give	e street and number			r Location of Death		4c. County		1.201
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2		27	Montgomery Ge 5. Social Security Number 6. S		JSPILAI je (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth			
Spr.	Funeral		1	M 2□XF	Ves	Months Days	Hours Min.	Month, Day,	Year)	Coun	lace (State or Foreign try)
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	and *	}	10a. State 10b. County	-	10c. City, Town or L	ocation				10	0d. Inside City Limits
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	death with the Maryland me 23a or 28a-1 ehow rmust be notified at	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W		try?
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	eme	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-		- America	
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Maryland 21215-0036	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	edent's Usual Occup	ation	kina	16b. Kind of Bu	siness/Ind	Justry
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21	gien er th	ő		6yr	s Onc	cologist			Insti	tute	e
b	oth oth	Be (17. Father's Name (First, Middle, Last))			18. Mother's Nam	ne (First, Middle, I	Maiden Sumami	a)	
ā	Hentz Feed	ToE	Alexei O	lshansky			Klavdi	a C	lshans	sky	
چ	should had had had had had had had had had ha	_	19a. Informant's Name/Relationship (Type, Print)	19b. Ma il	ing Address (Street	and Number or Ru	ral Route Number	. City or Town,	State, Zip	Code)
	od 2 Ith a 27 is		Lev Kharchenk	o - Husb	and 1263	30 Veirs	Mill R	d #1719	Rocky	/ill	e,MD2085
ē,	Hear Hear		20a. Method of Disposition			osition (Name of matory or other place		Date	20c. Location -	City or To	wn, State
ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If liem 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examiner must be notified at once.	0 1	1 ₺ Burial 2 □ Cremation 3 □								e, MD
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<u>ख</u>	ermi bepa npo ny ir		21. Signature of Funeral Service Licer	1589		2. Name and Addres					
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Division of Vital Records, P.	gner bed	by	Part II. Other significant conditions of	_		, ,	en in Part I.				e cause of death?
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	To the Hospital within 24 hours e To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Ph	nysician: To the best	of my knowledge, dea or examination and/or ii	th occurred at the tin	ne, date and place	and due to the ca	ause(s) and mar	nner as sta	ated.
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	Vit To Co	Σ	29b. Signature and title of certifier	1.		29c. Licens	e number	2	9d. Date signed	(Month, D	Jay, Year)
	3		Dr. Liluje He	-ui-Thing	indiv	DOUS	8542		HAY 15	200	06
)		30. Name and address of person who	completed cause of	death (Item 23a) (Type	, Print)			,	/	
			Dr. Libuse Her				gia Ave	#515 W	heaton	, MD	20902
	Sta	ite	31. Date filed (Month, Day, Year)								
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-				N. 190 AR.							

			1 - State Registrar	State of Man	•		of Health			giene	006	17301
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	0.00	3. Time of Death a
	Physici /Medio		Donald	M. Le	emon				May 13	, 20	06 Year	10:35 M
	Examir		4a. Facility Name (If not institution, give s 27678 Polo Court	treet and number)		,	own, or Location sbury	on of Death		1	county of Dea	
	Funeral Director		212 40 0771	7. Age (li 4м 2□ F 64	n yrs. last birthday, Yrs.	If Under 1 Months	Year If Und Days Hour	der 24 Hrs. s Min.	8. Date of Birth Month, Day 1/07/19	7. Year) 42	C	thplace (State or Foreign buntry) yland
	and *	1	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation						10d. Inside City Limits
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	7 28a	Director	10e. Street and Number		Daribbo	10f. Zip C	ode			10g. Citize	en of What Co	puntry?
	th with	ai D	27678 Polo Court			21	801			1	USA	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28s-f show or other traumatic event, the Maxical Examiner must be natilised at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Eve Armed Forces? Wyes 2 □ No If Yes, Give Year or Dates:	ar in U.S. 13. Army	Was Deceder If Yes, specification of the Period of the Per	Cuban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: W	
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr once.		20a. Method of Disposition 1		20b. Place of Dispo cemetery, cre WICOMICO	osition (Name matory or othe Memor	of er place) lal	5/18	ate NOS		ation - City or isbury	
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8760,	icate be executed physician and s the burial-transit	dicai Examiner	that inflated events cresulting in death) Last	Due to (or as a co	onsequence of):							
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Vital	i cian: T h certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Pla	ice of Death	(Check only or			
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Division o	tending Path. for: After I	ation:	27. Manner of Death SNatural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	f 28c	Injury at Work? 1 ☐ Yes 2		8d. Describe ho	ow injury o	occurred	
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į.	Da		30. Name and address of person who cor	nolated cause of dant	/ltem 22a) /T		3069	0	/	May 1	16, 2	DO C.
	10,7		Jones E. MAR	7/1 MI.	0. 14		Gree	115	1., 50	1:36	v . y ,	N.D.
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<u>,</u>	Physici /Medic Examin	al	1. Decedent's Name (First, Midd Edward 4a. Facility Name (If not institution	B. Lew	îs	4b. City, Town, o	or Location of Deat	May	Day Year 17 2000 4c. County of Death	3. Time of Death 06/0 M
	Funeral Director		FENIN SULA LEGIO 5. Social Security Number 315-38-9183 Usual Residence of Decedent	na/ Medica/ 6. Sex 7. Ag 18€M 2□F	e (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Ye	Wicomic ear) 9. Birthp Coun	Delaware
036	hours after death with the Maryland turel', or tteme 23a or 28a-1 ehow at Exertiner can be rediffed at	by Funeral Director	10a. State 10b. County Va ACCC 10e. Street and Number	Der Stree 12. Was Decedent Armed Forces? 1.579es 2 1	Ever in U.S. 13	otraque	333L Hispanic Origin? (S an, Mexican, Puert Specify:		Citizen of What Coun S. A. 14. Race - Americ Black, White, (Specify: Wh	an Indian, etc.
yland 21215-0036	Id be filed within 72 ental Hygiene. Ked other then "natic event, I'm Maric	To Be Completed	(Specify only higher Elementary/Secondary (0-12) 17. Father's Name (First, Middle	nt's Education sit grade completed) College (1-4or 5	16a. Dec (<i>Gi</i> (<i>if</i> e	eedent's Usual Occup ve kind of work done DO NOT use retire	Salcsman 18. Mother's Nar A++a	ne (First, Middle, Mai	etropolition	Justin
Baltimore, Mary	permit. Peges 1 and 2 shou Depertment of Heelth and M Importent: If Item 27 Ie mar eny Injury or other treumat QDG8.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3	3 □Removal from State Specify)	La 20b. Place of Dis	position (Name of rematory or other plate Memory 22. Name and Address	per St.	Chince Date 200 21-2006 7	c. Local of - City or To - City or To - City or To - City or To	wn, State
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	d the death. Do not ene. a consequence of):		neral Mem		ar Ailey	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed sie hes been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	dicai Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
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Records, P.	w requires that been signed t should be delt	Ď	Part II. Other significant condit	ons contributing to death b	ut not resulting in the	underlying cause gn	ven in Part I.	23e. Did tobace 1 ☐ Yes	co use contribute to the	e cause of death? ably 4. Unknown
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Division of Vital	ng Phys fter this ineral di	Certification; To Be	25. Was case referred to medical examiner? 1	Hospital: 1 / Inpatie 28a. Date of Inju (Month, Da) igation not be	y Year) 28b. Time Injury	of 28c. Injui	ner: 4 🗆 Nursing H	28d. Describe how i	t and Number or Rural	
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medicai C	29a. Certifier (Check only one) Centifyi	ng Physician: To the best Examiner: On the basis of and manner sta	f examination and/or	investigation, in my o	opinion, death occu	rred at the time, date	and place, and due to	the cause(s)
)	10 mg		1 Know	who completed cause of d	leath (Item 23a) /Tun		wolf	29d.	S-17.01	
/	VA Sta			uscoem h	ar's Signature	MINTOP Smalls	o Alo	Sm	usury mo	21804

			For State Registrar	State of M	aryland		artmeni rtificate					giene 2	006	17308
×	F. 192 "		Decedent's Name (First, Middle, La	st)						2	2. Date of Dea	ıth		3. Time of Death
6	Physici		Margaret Hele	en Lavfiel	d					1	Month	18 2	Year XXX	6:30 AM
1	/Medic Examin	4	4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of		-		nty of Death	, ,
* * * * * * * * * * * * * * * * * * *		3836	SALISBURY REHAB	& NURSING	CENTE	CR.	SALI	SBLIBS	Y, ME	218	204	DIT.C	COMTOO	
	Funeral		5. Social Security Number 6. S	ex 7. Ag		ast birthday)	If Under Months	1 Year Days	If Under Hours		B. Date of Birth (Month, Day	1	9. Birthi	place (State or Foreign
zi.	Director		169-40-2485	☐ M 2 ☑ F	57	Yrs.	MOTITIS	Days	Hours		eb. 5,	1949	PA	nuy)
	pu .		Usual Residence of Decedent 10a. State 10b. County		10- 0:5	Taum and a								
	aryla hov	_				, Town or Lo								10d. Inside City Limits 1X Yes 2 □ No
	8e-f	cto	MD Wicomi	co	Sa	lisbu	1							
	or 2	Director	10e. Street and Number				10f. Zip					10g. Citizen	of What Cou	ntry?
	ath w		200 Civic Avenue	•			1	1801				U.S.		
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	,		Was Deced If Yes, spec	lent of Hi	ispanic Ori n, Mexicar	gin? (Speci 1, Puerto Ri	ify Yes or No- can, etc.)		Race - Ameri Black, White,	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No		1 ☐ Yes 2	No 🍱	Specity:			Spe	cify: T.TL	nite
8	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow fre Medicel Exertirer mast be notified at	pa	15. Decedent's E			16a Dece	dent's Heur	I Occupa	ation			16b Kind of	Business/In	
<u>.</u>	n 72	Completed	(Specify only highest gra	de completed)		(Give		k done a	turing mos	t of working	7	TOO. KING O	D03111633/11	dustry
7	with the	mc	Elementary/Secondary (0-12)	College (1-4or	5+)		Нот	nemak	ror				Home	
Maryland 21215-0036	Hyg Hyg other		17. Father's Name (First, Middle, Last,)			HOI	icmap		er's Name (First, Middle,			
an	id be ental ked o	To Be	George Sipple						W.	ivian	Spedde	an.		
Ž	shound M	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a			Route Numbe		vn, State, Zij	Code)
ž	od 2 lith a 27 is r treu		Jennifer Wheatle	y (Daugh	ter)	3000	0 Dri	ftwo	ood D	rive	De 1ms	ar, MD	2187	5
ē,	F Heal		20a. Method of Disposition	y (Baugh	20b. Pl	ace of Dispo	sition (Nan	ne of		Dai		20c. Locatio		
0	age ant of rt: if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif							· 22	2000	D 1		7
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23s or 28e-f show any injury or other treumatic event, the Medical Exercises mainted at another.		21. Signature of Funeral Service Lices		St.		2. Name an				2000	Delm	ar, De	laware
Ba	Dep fmp eny		1 A Thurs	2.			hort				001mam	DE	100/0	
1 A	**		23a. Part1. Enter the disease, or com	plications that cause	d the death		3 E. er the mode				Delmar, respiratory ari		19940	Approximate
	District		shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.		-	10	3		-			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	26	er co		1	400	-1	(de	200		7101-
30	Examiner			Due to (or as	a consequ	derice or).							1	
	类。	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ience of):				,				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
<u>~</u>	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequ	ience of):								
8760,	e be rsicia e bur	dlcal		d.										
89	ificati g phy es the	edle												
ŏ	death certific e attending p ed for use es	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna		7-					23d.	Date of deliv	ery
\mathbf{m}	death e atte d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			JEctopic pro Other (sp.						Month	Day Year
o.	thet the de ted by the a deteched t	Physician/Me	9 Unknown	9Ll Unknown							,			
ري ح	The law requires thet the ste has been signed by the bage 2 should be deteched.	by P	Part II. Other significant conditions	contributing to death t	out not resu	ılting in the u	nderlying ca	ause grve	en in Part I		23e. Did to	bacco use c	ontribute to t	he cause of death?
ĕ	quire on sig uld b	pa	l								1 🗆 Y	es 2 Ak	3 ☐ Prol	oably 4 Unknown
00	aw require s been si should l	Completed									24a. Was a	an 24	b. Were auto	opsy findings available
R	The lav	E C									autop	med?	death?	impletion of cause of
tal		0	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes Check only or	2 No	1 ☐ Yes	2 No
of Vital Records,	Physician: r this certifici ral director,	ToB	examiner?	Hospital:	ent 2	ER/Outpatier	nt 3□ DO	Othe			e 5 ☐ Resid		Other /Saco	6.1
0	g Phy er thi		27. Manner of Death	28a. Date of Inju	ury	28b. Time of		8c. Injury Work			d. Describe h			97
Division	Attending ir deeth. actor: After by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n (Month, Da	ly rear)	Injury	м		<br Yes 2 □	No				
Vis	Atte	100	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of III	jury - At ho	me, farm, str	eet, factory	, office		28	It. Location (S	Street and Nu	mber or Rur	al Route Number,
Ö	in the c	Certification;	- Caromoldo	building, 6	tc. (Specify	7					City or Tow	siale)		
	Hospitei 24 hours a Funerai L		29a. Certifier 1 Certifying Pl	nysician: To the best	of my know	wledge, deati	h occurred	at the tim	ne, date an	d place, an	d due to the o	ause(s) and	manner as s	tated.
	he Hin 24 he Fi	Medical	(Check only 2 Medical Example one)	miner: On the basis of and manner st	or examinat tated.	ion and/or in	vestigation,	, in my or	pinion, dea	ith occurred	at the time, o	ate and plac	e, and due t	o the cause(s)
	To the l within 2 To the complet	Σ	29b. Signature and title of certifier	0			290	. License	number			29d. Date sig	ned (Month,	Day, Year)
	20		10/10/100	en			5	7 2	193	45	2	5/11	10%	
	123		30. Name and address of person who	completed cause of	death (Item	23а) (Туре,			1	1	-	/ /		
_	VV		WILLIAM ROBINS, M	.D. 200 C	IVIC A	AVE.,	SALIS	BURY	, MD.	218	04			
1	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signa	ture								

margaret Layfield

Phys	ician
/Me	dical
Exan	niner

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natures", or items 23s or 28s-f show any injury accorder traumatic event, its Madical Examinar must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours efter death.

To the Funeral Director; After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Of IV Registrar	arylan		artment Intificate						1/30/
K.	Decedent's Name (First, Middle, Last)			rimoure	0, 00		2. Date of De	Reg. No.	•	3. Time of Death
n	Anh Noor In						Month	Day	,	1:47 P M
al er	Anh Ngoc Le 4a. Fecility Name (If not institution, give street and number)		4b. City,	Town, or Loc	cation of Death	May .	15. 4c.	2006 County of Dea	
	Montgomery General Hospit				ney	Under 04 Use	1		Montg	omery
	5. Social Security Number 6. Sex 77. A		last birthday) Yrs.	Months		Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	y, Year)	C	thplace (State or Foreign ountry)
	Usual Residence of Decedent	73					Nov. 12	2, I	932 0	hina
	10a. State 10b. County	10c. City	, Town or L	ocation						10d. Inside City Limits
ţo	Maryland Montgomery		Silve	r Spri	ina					1 □ Yes 21 No
rec	10e. Street and Number		DIIVE	10f. Zip				10g. Citi	izen of What C	ountry?
Ξ Ω	13130 Broadmore Road			20	0904			C	hina	
nera	11. Marital Status 12. Was Deceden Armed Forces		S. 13.			nic Origin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Am	
Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 1 If Yes, Give Year or Dates:		1	1 ☐ Yes 2		nexican, Puerto Specify:	nican, etc.)		Black, Whi	
ted	15. Decedent's Education		16a. Dece	dent's Usua	I Occupation	n		16b. Ki	ind of Business	/Industry
npie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+)	life.	DO NOT us	e retired)	ng most of work	ing			
S	0		Но	memake					Own Hom	e
Be	17. Father's Name (First, Middle, Last)				18.		e (First, Middle,		Sumame)	
2	Li Yi Chouc		1				ou Char			
	19a. Informant's Name/Relationship (Type, Print)						al Route Numbe			
	Van Huynh/ Son	20h B	1293	2 Suga	arloaf		Road,			, MD 20871
	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	C	emetery, cre			1		20c. La	ocation - City or	Town, State
	4 Donation 5 Other (Specify)	Park	clawn Ma			May 20	06			Maryland
	21. Signature of Funeral Service Licensee		f:	rancis 00 Uni	J. C Lversi	ollins	Funeral	Hon	ne Inc. Sprin	g, MD 20901
	23a. Part. Enter the disease, or complications that cause shock, or heart lailure. List only one cause on each	d the death								Approximate Interval Between
	Immediate Cause (Final disease or condition	3 <1	- 60	().	9	Disa	100			Onset and Death
	resulting in death) Due to (or as	a consequ	uence ol):	CO	Cr	1) sec	ise			Syeams
	Cin	onic	He	Dal	275	Disec				
ner	Sequentially list conditions, if any, leading to immediate Due to (or as cause. Enter Underlying	a consequ	ence of):	J						
ical Examiner	Cause (Disease or injury that initiated events c.									
<u>.</u>	resulting in death) Last Due to (or as	a consequ	ience of):							
edica	d									
	IF FEMALE: 23b Was decedent program 23c. If yes, outcome	of pregna	nev							
lan	in the past 12 months?	2 Fetal	death 3	□Ectopic pre				1	23d. Date of de Month	livery Day Year
Completed by Physician/M	1 ☐ Yes 2 No 4☐ Figuration 9 ☐ Unknown 9 ☐ Unknown	it thine of de	editi St	Other (spe	eciry)					
<u>y</u>	Part II. Other significant conditions contributing to death	but not resu	ulting in the u	ınderiying ca	use given ir	n Part I.	23e. Did to	obacco u	ise contribute t	o the cause of death?
ed b	Type I Diabete	2					101	/es 2[¥No 3□P	robably 4 Unknown
piet	1.						24a. Was		24b. Were a	utopsy findings available completion of cause of
E							autop perfo 1 Yes	rmed? 2 DNo	death?	completion of cause of
Bec	25. Was case referred to medical				26	i. Place ol Deati	h (Check only o		10.10	2010
2	examiner? 1 Yes 2 No Hospital: 1 Inpat	ent 2 🗆	ER/Outpatie	nt 3 DO	A Other:	4 ☐ Nursing Ho	me 5 Resid	dence (6 □Other (Spe	icify)
E	27. Manner of Death 28a. Date of Inj 1 ☑ Natural 5 □ Pending (Month, D.	ury ay Year)	28b. Time o	of 28	3c. Injury at Work?		28d. Describe h	now injur	y occurred	
cati	2 Accident investigation			М		2 🗆 No				
Ē	determined 288. Place of Ir	jury - At ho tc. <i>(Specif</i>)	me, farm, st	reet, factory,	office		281. Location (S City or Tox	Street and vn. State	d Number or R)	ural Route Number,
ပ္သီ	29a. Certifier 1 Certifying Physician: To the bes									
Medical Certification; To	29a. Certifier (Check only one) 1 Certifying Physician: To the bess and manner s	ol examinal	wledge, deat tion and/or in	th occurred a rvestigation,	at the time, of in my opinio	date and place, on, death occurr	and due to the red at the time,	cause(s) date and	and manner as place, and du	s stated. e to the cause(s)
ž	29b. Signature and title of certifler			29c.	License nu	mber			e signed (Mon	th. Day, Year)
	Stan PH	Sic	IAN	1 6	031	68		5	15/01	6
	30. Name and address of person who completed cause of	death (Item	23а) (Туре,					•	1	20850
	Styam Parkine M 31. Date liled (Month, Day, Year) 32 Regist	rar's Signa	4901	ME	DICA	L CEN	ITERI	DR. i	ROCKU	LLE, MD
te ar	MAY 17 2006	ais signal	K A	solv.						

DHMH 17 Rev 1/2001

State

Registrar

			1 - For State of Ma		artment of I	Health and Men Death	tal Hygier		17308
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Leo R Mango	10			Date of Death Month	Day Year /4, 2006	3. Time of Death
	Examin Funeral	er	1 \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	e (In yrs. last birthday)	891	Hours Min. (Date of Birth	Ac. County of Deeth Of Ing. 9. Birthol County Of Deeth	ace (State or Foreign
	Director		192-30-9890 Usual Residence of Decedent 10a, State 10b. County	65 Yrs.	ocation	Ma	rch 17,	1941 Allen	town, PA
	after death with the Maryland or Iteme 23s or 28s-1 show culrer must be notified at	Funeral Director	MD Cecil		ake City				1 ☐ Yes 2X☐ No
	with the or 2	Dic	10e. Street and Number		10f. Zip Code	-	-	Citizen of What Coun	try?
	eath ne 23	eral	137 Woodside Drive 11. Marital Status 12. Was Decedent I	Ever in U.S. 13.	21915 Was Decedent of h			USA 14. Rece - America	an Indian.
036	or Ite	þ	1 Never Married 2 Married 1 X Yes 2 New Year or Dates:	1962-65	If Yes, specify Cub 1 ☐ Yes 2 【X No	Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	n, etc.)	Black, White, e	etc.
215-0	nin 72 hours in "naturel", Medical Ext	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	16b.	Kind of Business/Ind	lustry
212	ad within /giene. er than "	Com	2+		nication	T		elephone C	ompany
Maryland 21215-0036	s 1 and 2 should be filed wit f Health and Mental Hygiend item 27 is marked other thu other traumatic event, the	To Be	17. Father's Name (First, Middle, Last) Sidney O.F. Mangold			18. Mother's Name (Fin		len Sumame)	
Man	12 sho h and 7 is m		19a. Informant's Name/Relationship (Type, Print)			t and Number or Rural Ro			
	s 1 and 3 if Health item 27 other tr	- 4	Maryann H. Mangold/daughte 20a. Method of Disposition	20b. Place of Dispo	osition (Name of	uny St., Pot	20c	Location - City or Tox	
ē	Pages lent of nt: If i		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		matory or other pla Garden (05-18-2 Memories	006 Lis	merick. Pe	nnsylvania
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ess of Facility R.T. 2 Street, Ch	Foard Fo	uneral Hom	e, P.A.
اء	Physician		2.1 Pert1. Ent. the disease, or complications that caused shock, heart failure. List only the cause on each lir Immediat Cause (Final diseas or condition	the death. Do not ent					Approximate Interval Between Onset and Death
8760,	certificate be executed management and more as the burial-transit	dical Examiner	Esquentially fist conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that inditated events	a consequence of): Dr UR4; a consequence of): ZURS a consequence of):	icle b	Accides		A.F.	
P.O. Box 6	that the death certifica led by the attending ph detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	ATT WAY			ry Day Year
	The law requires that the death tie has been signed by the atter bage 2 should be detached for u	by P	Part II. Other significant conditions contributing to death be	ut not resulting in the u	underlying cause gr	ven in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the	~_/
al Reco		Completed	Seps. S				24a. Was an autopsy performed 1 ☐ Yes 2 D	prior to com death?	psy findings available apletion of cause of
<u> </u>	ysician: Is certific director,	To Be	25. Was case referred to medical exampler? No Yes 2 □ No Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA Ott	26. Place of Death (Ch		6 ☐ Other (Specify))
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification; T	27. Manner of Death 1	ry 28b. Time o Injury	ef 28c. Inju Wo	ry at 28d. rk? Yes 2 100 Mg	Describe how in	ijury occurred	ish to pole
	tospits hours uneral	edical C	29a. Certifier (Check only Medical Examiner: On the basis of	of my knowledge, deat	th occurred at the tr	me, date and place, and opinion, death occurred a	due to the cause	(s) and manner as sta	ated.
	To the H within 24 To the F complete	Medi	29b. Signature and title obsertifier	ated.	29c Licens	se number	294 [Date signed (Month I	Day, Year)
			30. Name and address operson who completed cause of d	eath (Item 23a) (Type,	Print)	053850 Kernas /1	1	Ry 14,20	-
15	+ IVA		Steles J. Schu	vertz, v	45 1	Cernas /	asp, fe		
	Sta Registi		31. Date filed (Month, Day, Year) 6 2006 32. Figistra	ar's Signature	parte				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 2:04 P M May 17 2006 Deareary David Massey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Hagerstown 64 Wayside Ave. Hayer Stown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

June 29, 1948 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XXM 2□ F 57 West Virginia Director 236-78-7727 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show empirication or other fraumatic event, the Medical Examination must be nutified at once. 10a. State 1 Yes 2 No Directo Washington Hagerstown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 USA 64 Wayside Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No If Yes, Give 1967 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Scrap Metal 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Ward Massey Oliver ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hagerstown, MD 21740 Darlene E. Wentz - Per. Rep. 64 Wayside Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 05-19-2006 | Smithsburg, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athoroschoutic **Physician** Lozonaz Vasular Disacre /Medical Due to (or as a consequence of) Examiner >10mrs 1050116 Abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No within 24 hours after death.
To the Funeral Director: After this completely filled in hours. 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?
Yes 2 No Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056965 MAY 18, 2006 Diget Med. I Bonin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antiden 5H-4+1 Hogiston 251 5-1001 mo Steehen KoteL 2. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State MAY 19 2006 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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	D .		Usual Residence of Decedent									
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ith the Mary or 28a-f shu	Director	10e. Street and Number	rroll O Antrim Blvd		Та	neyto	Code	1787		1	0g. Citizen of	What Cour	1 XYes 2 □ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "To hours after death with the Maryland Important: If item 27 is marked other then "naturel", or Iteme 23s or 28s-f show eny injury or other treumstic event, the Medical Examinar must be notified at engines.	Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	12. Was Decedent Armed Forces?	Ever in U.S.		Was Deced	lent of His		gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	14. Ra Bl	ice - 'Americ ack, White, ify: Wh	
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06-03451

Please Type or Print in Black Indelible Ink

Betty Partin		For State	of Maryland / Depa <i>Cei</i>	artment of rtificate of		Mental Hy		No. 200	6 1731
Physician	7 1	e gistrar , Decedent's Name (First, Middle,Last)				2	Reg. 2. Date of Death Month D	oay Year	3. Time of Death
Medical Examine		Eetty a. Facility Name (if not institution, give	Partin street and number)		o. City, Town, or Lo	cation of Death	May 21, 200	4c. County of Death	1450 hrs
	ľ	9615 Gwynndale Avenue	Street and Hambery		Clinton	odilor or bodin		Prince George	
Funeral Director			7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(March 3	MM/DD/YYYY) 9. Bir 31,1937 Foreig	thplace (State or Invirginia untry)
od how any ce.	1	Isual Residence of Decedent Oa. State 10b. County Maryland Prince Ge	eorge's	, Town or Locatic	n linton			· · · · · ·	10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.		0e. Street and Number 9615 Gwynndale Di	rive		10f. Zip Code 2073			U.S.A.	
ter death wi		1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year	If Ye	Decedent of Hispa s, specify Cuban, M Yes 2 X No s	Mexican, Puerto R		14. Race - Amer White, etc. Specify: Wh:	ican Indian, Black,
a : =1 %		15. Decedent's Education (Specify online Elementary/Secondary (0-12)	or Dates: y highest grade completed) College (1-4 or 5+)		s Usual Occupation st of working life. D Tary		ork done	6b. Kind of Business/ Governmen Dept. of	t
		7. Father's Name (First, Middle, Last) Robert Blease	Alexander		18	Myrt1	First, Middle, Ma e Mae Da	iden Surname) NVIS	
I die is in its		9a. Informant's Name/Relationship (Ty Christina Munson		_				er, City or Town, State adon,VA 20	, ,
s I and St Health	2	Oa. Method of Disposition Burial 2 Cremation 3	Removal from State	Place of Disposit crematory or oth ee Crema	ion (Name of ceme er place) tory	May	24.	20c Location - City or Clinton, M	-
Baltimo permit Page Department of Important: injury or ott	1	21. Signature of Funeral Service Licens	ee					Home. In	on, MD20735
Physician /Medical	- 4	3a. Part I. Enter the disease, or complifailure. List only one cause on each	ch line.	n. Do not enter th	e mode of dying, su	ich as cardiac or	respiratory arres		Approximate Interval Between Onset and Death
Examiner			Hypertensive At		otic Cardio	vascular 1	Disease		300
	luer	cause Enter Underlying Cause	Due to (or as a consequence of	of):					
ted Insit			Oue to (or as a consequence of	of):					
O, che executed sisician and burial - transit	- dica	X UNPENDED	AMENDED item#23a	a,PII,27,p	erME,g857,	7/10/06 T	Γ	المراج المتاري	
Ox 6876 anh certifican attending phy for use as the	2 Sician/I	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of do 9 Unknown	2 Fet	al death 3 ener (Specify)	Ectopic pregnan	ncy	23d. Date of deliver Month	y Day Ye ar
hat the ed by the detached		Part II. Other significant conditions	9		nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the draw attendent at a birector. After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	Completed by	Emphysema, Fatty Li	ver, Diabetes re.		-		24a. Was an autopsy perform	24b. Were at prior to death?	utopsy findings available completion of cause of
tal Rec	장 - 왕	25. Was case referred to medical examiner?	applied:			f Death (Check o	nly one)		
fing Ph	의	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatient	njury 28c. Injury			esidence 6 🗸 Othe w injury occurred	r: Scene
Division Division Of the Huspital or Attent Within 24 hours after death For the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determine to determine to the could not be a could not to determine to the could not be a could not to determine to the could not be a c	28e. Place of Injury - At h	home, farm, stree	t, factory, office bui	lding, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
To the Hos within 24 h Fo the Fini completely	Medical		an: To the best of my knowled On the basis of examination and manner stated.						
2 3 2 9	Me	29b. Signature and title of certifier	_ MD		29c. License O.C.M			29d. Date signed (Mo May 22, 2006	onth, Day,Year)
	Ī	30. Name and address of person who a Ana Rubio MD. Assistar			treet, Baltimor	e, MD 21201			
Sta Registr	te	31. Date filed (Manth, Day, Year)	2. Registrar's Signa	ture	2)	-			٠.
DHMH 17 Rev 1/200			A James No.	ORIGINA	L				

			1 - For State Registrar	State of M	laryland		artment rtificate			and M		giene /	200	5	17315	j
	Physici /Medic		1. Decedent's Name (First, Middle, Las RNODA AV	"I'ene	POE						2. Date of Dea	Day 2	200	3.	Time of Death	
,	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, 1	Town, or	Location o	of Death		4c. C	County of De	ath		
			Washington County					erst		2411			shingt			
	Funeral		5. Social Security Number 6. S	9x 7.A/ □M 250F	ge (In yrs. las 82	st <i>birthd</i> ay) Yrs.	If Under Months		Hours	Min.	8. Date of Birt. (Month, Day	y, Year)	9. Bi	rthplace country)	(State or Foreign	
	Director		196-14-1038 Usual Residence of Decedent								Sept 1	1923	N	[ary]	and	_
	yland how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Ir	nside City Limits	
	e Mar	cto	Maryland Washing	gton	H	agers	town							1	☐Yes ZX No	
	or 28	Dire	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What C	ountry?		
	ath w	rai	17528 Woodlawn Di					1740					SA			
	iteme	nue	11. Marital Status	12. Was Decedent	?	. 13.	Was Deced f Yes, spec	ent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	. 14	t. Race - Am Black, Wh		dian,	
36	72 hours after death with the Maryland neturel; or iteme 23a or 28a-f ehow iteal Exam, at must be notified at	by F	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√2 If Yes, Give Year or Dates:	:		1 ☐ Yes 2	X No	Specify:			9	Specify:	Wh	ite	
21215-0036	2 hou	ted	15. Decedent's Ed	lucation		16a. Deced	dent's Usual	Occupa	ition			16b. Kind	d of Busines			
218	within 7 ene. than "n	ple.	(Specify only highest gra	de completed) College (1-4or	5+)	lite.	kind of worl DO NOT us	k done d e retired)	uring most)	t of workii	ng					
	filed wi Hygien ther th	Completed by Funeral Director	8	0		Но	nemake				-		own h	ome		
and	od ia b od ia b	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		iumame)			
Maryland	2 should be and Mental is marked o	၉	Ray Diehl Jr. 19a. Informant's Name/Relationship	Type Print)		10b Mailie	a Addrass	(Stroot o		128	il Hess		Town State	7:- 0- 4	-1	
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Ę	Peges nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		' .		Cemet		1	/25/	06	Pour	ervill	o D		
Baltimore,	# # # # # # # # # # # # # # # # # # #		21. Signature of Funeral Service Licen	S88	- 0		. Name and				nnich F				a.	7
m	Per Imp Per Imp		->cott	m//) u	une	4	15 E.	Wil:	son B		Hager				40	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	d the death.	Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest,		Inter	roximate rval Between	
-	Physician		Immediate Cause (Final disease or condition	. Kypy	ned	Ah	danl	Au	Uni	An	48-			1 he	et and Death	
	/Medical Examiner		resulting in death)	Due to (or as	s a conseque	nce of):					1					1
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a conseque	nce of):								90	0165	
	nted f	Examiner	cause. Enter Underlying Cause (Disease or injury											•		
ó	be executed sicien and burial-transit		that initiated events resulting in death) Last	Due to (or as	s a conseque	nce of):										_
8760,	# 5 E	icai	(d												
ø	death certifica attending ph d for use as th	Physician/Medical	IF FEMALE:													_
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal d	eath 3	Ectopic pre					23	d. Date of de Month	Day	Year	
o.	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	at time of dea	th 5∟	Other (spe	ecify)						,		
Q _	res that ti igned by be detai		Part II. Other significant conditions of	ontributing to death	but not result	ing in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	e contribute	to the cau	use of death?	
Records,	quires n sign	d by									1 □ Y	es 2□	No 3□F	robably	4 Unknown	
00	aw requir s been si 2 should l	ojete									24a. Was a		24b. Were a	utopsy fi	ndings available	_
R	The lav	Completed									autop perfor		prior to death? 1 🗌 Ye		ion of cause of	
Vital	ysicien: Th is certificete director, pag	BeC	25. Was case referred to medical examiner?			/			26. Place	of Death	(Check only or					_
of V	Physic this or	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati		P/Outpatien			4 🗀 Nui		ne 5□Resid			ecify)		_
u C	ding F h. After funera	io	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year) 2	8b. Time of Injury		C. Injury Work			8d. Describe h	ow injury	occurred			
Division	Attending Physicien: r death. sctor: After this certifice by the funeral director.	licat	2 Accident investigation 3 Suicide 6 Could not be	1	niury - At hom	e farm str	M eet factory		'es 2 □ N		28f. Location (S	treet and	Number or F	Bural Rou	te Number	_
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	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Exam	ysician: To the best	t of my knowl	edge, death	occurred a	t the time	e, date and	d place, a	and due to the o	ause(s) a	nd manner a	s stated.	201100(=)	_
	To the H within 24 To the F complete	Medical	one) 29b. Signature and the of certifier	and manner s	tated.			License						_		
	N W G	_	b Nh IIL) A))		290.	7	-//	· ~		MA	signed (Mon	1.	11/1	
			30. Name and a dress of person who	completed cause of	death (Item 2	(3a) (Type	Print)	1/2	la /2	5 3		117-11	Lay.	M	VV	_
É	4-4			UV	0 N	uhu	51	1110	The	lical	Camp	us k	ed 1.	tro.	Md	
12	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	trar's Signatur	re A	0.20 2		, ,		- 7			1		

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		1- For State Registrar				Cert	ificate (of Dear	th			Re	g. No.	200	6 1731	
Physicia	ın/	1. Decedent's Nam	ne (First, Midd	le,Last)			_					te of Death	h Day	Year	3. Time of Death	
Medical Examir		Nichola									Ma	y 18, 20	006		0022 hrs	
		4a. Facility Name (`	-	et and number)			Town, or ndship	Location of	Death			County of Dea Vorcester	ith	
		Route 113			17.46	so (lo uno los	t bietheleus			r If Under:	24Ura 0 F	ate of Rid			irthplace (State or	_
Funeral Director	- 1	5. Social Security I		6. Sex		ge (In yrs. las		Mont	der 1 Yea		Min			Fore	eign	
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any	-	Usual Residence of 10a. State	10b. County			10c. City, T	own or Loc	ation		-					10d. Inside City Limits	S
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offer of II", or	by F	3 Widowed	4 Div	orced If Yes	s, Give Year	111 110	1	Yes 2	2X No	specify:				Specify:	White	
ours?	d b	15. Decedent's E	ducation (Spe			mpleted)				tion (Give kir		one	16b. K	(ind of Business	s/Industry	
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5-0036 led within 7 Hygiene other than	Comple	12						Stude								
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2121 ould be fi Mental i marked c event,	Be	Albert V					19h Mail	ina Addrae	s (Strac		ne 01t		hor Ci	ty or Town, Sta	to Zin Codo)	_
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and 2 ealth item 2	ŀ	20a. Method of Dis				20b. Pl		osition (Na			Date			ocation - City o		-
Baltimore, permit Pages I at Department of Hee Important: If ite		1 X Burial 2		Lanca and	emoval from S	late		other place			E /01		_			
tim trant		4 Donation 5	Other S	pecify:		RIV		e Cen		s of Facility				erlin,		_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of F	meral Service	Licensee	0						2110			Funeral	Home	
Physician		23a. Part I. Enlart	the distase, or	complication	that caused	d the death. I				m St.			_		Approximate Interval	<u></u>
/Medical		failure. List or	nly one cause	on each in	ie.							ĺ			Between Onset and Death	ŧ
Examiner		Immediate Cause or condition result		_	ple Injuries o (or as a cons		:									—
K.,		Sequentially list of	onditions	b.	,											
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vecuted n and - transit		events resulting in	rdealii) Lasi	_ d.	,	,										
5 5 6 E	ical	UNPENDE)	АМ	IENDED											_
P.O. Box 68760, that the death certificate be extending by the attending physician detached for use as the burial-	ician/Medi	IF FEMALE:		23	sc. If yes, outco	me of pregna	ancy						230	d. Date of delive	ery	-
587 srtific ling p	ar	23b. Was deceden past 12 month		he 1	Live birth			Fetal death	1 3	Ectopic p	pregnancy			Month	Day Year	
Box (e death ce the attended for use	S	1 Yes 2	No 9 Ur	known 9	= •	t time of dea	th 5	Other (Spe	ecify)							
the de	Phy	Part II. Other sign	nificant condi		L	th hut not res	sulting in th	e underlyin	n cause o	niven in Part	1 2	3e. Did tob	bacco	use contribute t	o the cause of death?	_
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	þ	Turchi other orgi			induing to dod		January W. W.	o andonym	ig oddoo ;	gitaitit					obably 4 Unknown	
ls, land	fed											4a. Was a			autopsy findings available	e
Orc aw re nas be	흷											autops	sy		completion of cause of	
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Division ral or Attendii rs after death. al Director: A	Certification:	2 🗸 Accident		estigation												
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Dspita		4 Homicide			(Specify) Ro									ute 90, Frier		-
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Sa	runeck only .												d manner as sta ce, and due to		
Tot with Tot	Medical	29b. Signature an		and	manner stated					se number					lonth, Day, Year)	_
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

		_	State of Maryla	•			ntal Hygie	ne 2006	17317
			Registrar 1. Decedent's Name (First, Middle, Last)	Ceri	tificate of l		Reg. Date of Death	Not. U U U	3. Time of Death
	Physicia	an	1. pecadent's Name (First, Middle, Last)	Po	llen			Day Year 200	6 5:30PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	16 -11	4b. City, Town, or	Location of Death	- 1	4c. County of Dear	th
			5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		448-14-1924 1□M 2\(\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exititt{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\exitititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\	Yrs.	Months Days	Hours Min. J	une 13,	³² 1924 0kf	ahoma
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Loc	cation				10d. Inside City Limits
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	r 28e	Director	10e. Street and Number		10f. Zip Code			. Citizen of What Co	
	23e o	ral D	700 Americana Drive Apt 28		21403			ited Stat	
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumetic avant, the Medical Evantral retrained to hottlised.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces ? 1 □ Yes 2 ② No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I□Yes 2ሺ No	lispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	/ Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify:	
2-0	72 hou nature	eted	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occup	during most of working	168	b. Kind of Business	/Industry
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/lan	12 should be filed within "n and Mental Hygiene." Is marked other than "raumetic avant, the Me	To B	Samuel H. Tarr			Lilly Pear			
Maryland	12 sho h and 7 Is mu rraum		19a. Informant's Name/Relationship (Type, Print)			and Number or Rural R Parkway An			
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e E	Pages nent of int: If i		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ort Line	oln Crem	atory 7/10/2	Br	entwood,	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Funeral Sequice Licensee						al Home, Inc.
	⊄ □ E et al	Н	23a. Part1. Enter the disease, or complications that caused the de	ath. Do not ent	47 Duke of dyir	of Gloucest ng, such as cardiac or re	er St. espiratory arrest	<u>Annapoli</u>	s MD 21401 Approximate
	Pnysician		shock, or heart failure. List only one cause on each line.	noo					Interval Between Onset and Death 50 minutes
1	/Medical		disease or condition resulting in death) a Due to (or as a consi	sequence of):	7	ma			ED as 1
	Examiner	<u>_</u>	Sequentially list conditions, if any leading to immediate b. Due lo (or as a cons	Karal	TN+	arction	1		50 minutes
	uted d ansit	Examiner	Gause (Disease or injury that initiated events	Rus F	Rtorv	Disea	LSC		5 years
ó,	an and	Exa	resulting in death) Last Due to (or as a cons	equence of).*					
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dical	d					- Ardin	
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. Date of de	alivery
	death e atter	icia	in the past 12 months? 1 Yes 2 No 9 Unknown		JEctopic pregnancy Other (specify)	у		Month	Day Year
P.0	that the de ed by the detached	Phys	9 Unknown Part IL Other significant conditions contributing to death but not r	resulting in the u	nderlying cause div	ven in Part I	23e. Did tobac	cco use contribute t	to the cause of death?
ds,	gn ga	d by	Meningiama, SIP	Rec	ent 1	Resection	1 Yes	2 □ No 3 □ P	Probably 4 ⊡Unknown
COL	s been si should	ompleted	Soizure Diso	rder		1	24a. Was an	24b. Were a	utopsy findings available completion of cause of
l Re	The lay	mo					autopsy performe 1 Yes 2	d? death?	
Vital Records,	Physician: T this certificat ral director, pi	BeC	25. Was case referred to medical examiner?		Ott	26. Place of Death (Coner.			
of		To To	1 Yes 2 1 No 1 Manner of Death 28a. Date of Injury	28b. Time of	f 28c. Inju	ry at 280	5 🗌 Residend J. Describe how	ce 6 □Other (Spe injury occurred	ecity)
ion	Attanding F death. ctor: After y the funera	atlor	1 Matural 5 ☐ Pending (Month, Day Year, 2 ☐ Accident investigation	r) Injury	M 1 □	rk?]Yes 2□No			
Division	br Atterde lit	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe		reet, factory, office	28f	. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune		29a. Certifier 1 Certifying Physicien: To the best of my	knowledge, deat	h occurred at the ti	me, date and place, and	d due to the caus	se(s) and manner a	s stated.
	he Ho n 24 h ha Fu	Medical	(Check only one) 2 Medical Exeminer: On the basis of exam and manner stated.	ination and/or in					
	To t To t	Σ	29b. Signature and title of certifier	MD	29c. Licens	se number	29d	J. Date signed (Mon	III, Day, Year)
			30. Name and address of person who completed cause of death (I	Item 23a) (Type	Print)	0-000	7	1 1 27 1	7 2000
			Tamer Abdelhak	600.	N. Wol.	Fe Street	Ball	timore	MU 21287
:	St	ate	31. Date filed (Month, Day, Year) 32 (legistrar's Sig	gnature	Sall a				

			. For	State of M							•		_	\$ 50°F 10°F	1.0
			1 - State Registrar			Cei	rtificate	e of L	Death			Reg. No.	2006	1/3	18
'n	Physicia	an .	Decedent's Name (First, Middle, Last)							Date of De Month	Day		3. Time of E	
	/Medic	al	David E. Rumburg				4h Cih.	Tour or	Location o	of Dooth	May	14	2006 County of Deet	05:00	A ^M
	Examin	er	4a. Fecility Name (If not institution, give 6 Mulberry Lane	street and number)	,		Berl		Location) Deali			rcester	*1	
-	Funeral		5. Social Security Number 6. Se		ge (In yrs. last bi	rthday)	If Under	1 Year	It Under		8. Date of Bir (Month, Da		9. Birt	hplace (Stete or	Foreign
	Director		220-42-6672	∑ M 2□F	58	Yrs.	Months	Days	Hours	Min.	9/26/	47	Wes	t Virgir	nia
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c, City, Tow	m or Lo	cation							10d. Inside City	Limits
	/anyla	ō	10a. State 10b. County 10c. City, Town or Location Maryland Worcester Berlin										1 ☐ Yes 2 🔣 No		
	28a-	Directo	10e. Street and Number	•			10f. Zip	Code				10g. Cit	izen of What Co	untry?	
	death with the Maryland me 23a or 28a-f ehow r must be notified at	al D	6 Mulberry Lane				218	11				USA			
	eme ?	Funeral	11. Maritat Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Ame Bleck, White		
36	s after	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give	No		1 ☐ Yes 2		Specify:				Specify:		
Maryland 21215-0036	within 72 hours after ene. than "natural", or Ite he Medical Examera	ed b	15. Decedent's Edi	Year or Dates:		. Deced	dent's Usua	I Occupa	ation	-		16b. Ki	ind of Business/	nite Industry	
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<u>ya</u>		၉	James E. Rumburg		401	B 4 - 181			Peggy			- 07	- T Chat-	7- O- d-1	
Mai	E = 20 2		19a. Informant's Name/Relationship (7)								,Maryla		r Town, State, 2 1911	ap Code)	
ည်	s 1 and of Health item 27 other to		Concetta Rumburg/I	ATTE	20b. Place o	f Dispo		ne of			Date Y I d		ocation - City or	Town, State	-
OE.	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ 1 ☐ Dentation 5 ☐ Other (Specify		Salis	•	-		1	5/17	/06	Sali	chury.N	Maryland	
Baltimore,	글 튼튼을 .		21. Sign ture of Funeral Sen ice Licens	A	Salis						ne P.A.	Days	SDULY/I	ar y rand	
m	Depa Impo eny i		1 Amy ly	OVIN	ez.	50	1 Sno	w Hi	ill Ro	d. S	alisbur	y,MA	ryland	21804	
de			23a. Part 1 Enter the disease, or compositors, or heart failure. List only of	lications that cause one cause on each I	d the deam Do line.	not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	rest,		Approximate Interval Betw Onset and De	een
Z	Pnysician		Immediate Cause (Final disease or condition	a. Th	rign	N	A							Offiset and De	Jatri
Ö,	/Medical Examiner		resulting in death)	Dun to or as	s con equence	of):									
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89 2	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	20. (1											
Box	leath certifica attending plant of for use as t	ian/	in the past 12 months?		e or pregnancy 2 □ Fetal death at time of death		Ectopic pro					- 1	23d. Date of deli Month		ear
o.	that the de led by the a detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time or death	3	_ Other (spi	ecity)				1			
٥.	igned by	by Ph	Part II. Other significant conditions co	ontributing to death i	but not resulting	in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco u	ise contribute to	the cause of de	ath?
rds	quires n sign	d b									10	res 2	□No 3□Pr	obably 4 🗆 Ur	iknown
000	aw requires s been si 2 should l	plet									24a. Was		24b. Were au	topsy findings av	vailable
æ	The lav ate has page 2	Completed									perfo	rmed2 20 No	death?	2□ No	130 01
/ita	ertific sctor,	Be (25. Was case referred to medical examiner?					Tou		of Deat	(Check only o	ne)		11.50	
5	Physician: r this certifica ral director, p	은	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inj		utpatier		8c. Injury	4 140	-	me 5 Hesi		6 Other (Spec	cify)	
no	ding h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Di		Intury	M	Work	k? Yes 2 □		200. Describe	IOW III WOI	yoccurred		
Division of Vital Records,	Attendir death.	ifica	3 Suicide 6 Could not be	28e. Place of In	njury - At home, t	arm, str	eet, factory			-	28t. Location (Street an	d Number or Ru	ral Route Numb	er,
Ö	s after	Certification:	4 Homicide	building, e	itc. (Specify)						City or To	vn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best	t of my knowledg	e, death	h occurred a	at the tim	ne, date an	id place, ith occur	and due to the	cause(s)	and manner as	stated. to the cause(s)	
	within 24	Medical	one)	and manner s					number				e signed (Mont)	``	
1	5 × 5 §		29b. Signature and title of certifier	2	77		230	. Eloonise	/ -			230. Dai	/ / /	i, Doy, real)	
,	34		30. Name and address of person who c	completed cause of	death (Itam 22-1	(Tues	Print	HS	17	18		5	1.61	06	
	ZQ7.		Joseph McShea	ompleted cause of 10514 Ra			,	rlin	, MD	2181	1				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature				,		-				
	Registi	rar	MAY 182	006	one &	1	frank .	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MAY 25 2006 10:30 P M LEONA MARY RANKIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JUNE 7 1921 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2X F MARYLAND 215 20 7097 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, I'ra Medical Examinat must be notified at XX Yes 2 No Director MARYLAND FROSTBURG ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 183 ORMOND STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: ģ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BRANCH MANAGER BANK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ETTA RIZER RICHARD LaRUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS RANKIN / SON 249 CENTENNIAL STREET, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOHNSON CEMETERY 5/29/06 FROSTBURG, MD 21. Signature of Funeral Service Licensee 60 WEST MAIN STREET 22. Name and Address of Facility 150 WB SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 M00547 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBRO VACCULAR ACCIDIZATI about 20 monte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2₽No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 126907 MAY 26, 2006 Helm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT S. SIDHU, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 1 2006 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH G887 2 /2 / 09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 26, 2006 MAY 11:20PM CLARA ELOIS RICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12550 RICE'S PLACE NEWBURG CHARLES If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X X Yrs 69 Director JULY 6,1936MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c City Town or Location 10a, State 10b. County i7 is marked other than "natural", or items 23a or 28a-1 ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No NEWBURG MARYLAND CHARLES Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 12550 RICE'S PLACE 20664 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married X XMarried 1 ☐ Yes 2XXXIo Specify: Specify: WHITE þ 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify onty highest grade completed) Complet and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be RICHARD BOWLING CLARA MAYER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heath a Important: If item 27 is any injury or other trai JARRETT L. RICE-SPOUSE 12550 RICE'S PLACE, NEWBURG, MARYLAND 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Yurial 2 ☐ Cremation 3 ☐ Removal from State 5-31-06 4 ☐ Donation 5 ☐ Other (Specify) CHRIST CHURCH CEM. WAYSIDE, MARYLAND 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence off Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last sician and Due to (or as a consequence of). Box 68760 Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-33426 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 B. LARRY JENKINS MD 111 LAGRANGE AVENUE LA PLATA MARYLAND 20646 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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П	Physici	an	Decedent's Name (First, Middle, Las	_						Date of Death Month	Day Year		
	/Medic		George William Ro			4b. City, T	own, or	Location of	Death	May 16	2006 4c. County of De	6:15 P ^M	
	LXattilli	C1	13452 Clopper Rd				Насе	erstow	m			ngton	
	Funeral		Social Security Number 6. Se	9x 7. Age (In XM 2□ F	yrs. last birthday) Yrs.	If Under 1	Year Days	If Under 24	Min. 8.	Date of Birth (Month, Day, Y	(ear) 9. B	irthplace (State or Foreign Country)	
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	nyland thow	L	10a. State 10b. County	100	. City, Town or Lo	ocation						10d. Inside City Limits	
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	with the	by Funeral Director	10e. Street and Number			10f. Zip 0				10g	J. Citizen of What (Country?	
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9	or Ite	/ Fur	1 ☐ Never Married 2 🙀 Married	Armed Forces? 1 ∏Yes 2 ☐ No If Yes, Give		lt Yes, specif 1 □ Yes 2 l		n, Mexican, I Specify:	Puerto Rica	an, etc.)	Black, Wh	ite, etc.	
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21215-0036	within 72 hours after death with the Maryland ene. then "raturel", or llems 23a or 28a-f ehow he Madical Exander must be motified at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual <i>ki</i> nd of work DO NOT use	done di	uring most o	of working	16	b. Kind of Busines	s/industry	
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Ĕ	ment ment tant: h		4 Donation 5 Other (Specify		arklawn	Mem P	ark	Ма	y 19,	2006	Rockvill	e, MD	
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	Physician		shock, or heart failure. List only c Immediate Cause (Final disease or condition	xte cause on each line.	Pai	kinso	n¹e	Diggs	60			Interval Between Onset and Death	
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, S	8 5 g		Part II. Other significant conditions co	intributing to death but not	resulting in the u	nderlying cau	ise giver	n in Part I.				to the cause of death?	
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ital		Be C	25. Was case referred to medical					26. Place of	-	1 ☐ Yes 2 to neck only one)	No 1	s 2□No	
<u>></u>	hysic this ce al direc	ဥ	1 192 5 X 140		2 ER/Outpatier			4 Nuisi	ing Home	5 X Residenc	e 6 □Other (Spe	əcify)	
uc	Jing Afte	:lou:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	M 280	Work?	at ? es 2∐No		Describe how	be how injury occurred		
/isi	i or Attending Physician: efter death. Director: After this certifics in by the funeral director.	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	At home, farm, str			83 2 140	28f.	Location (Stree	et and Number or R	ural Route Number.	
ā		Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecity)					City or Town, S	State)		
	To the Hospital or within 24 hours efter the Funaral Dir completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my iner: On the basis of exam	knowledge, death	occurred at vestigation, in	the time	, date and p nion, death	olace, and o	due to the caus	e(s) and manner a and place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certified	and manner stated.			License				Date signed (Mon		
)	F>F0		· MM	111	M.D		חחת	61411			May 18,		
	1		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type,	Print)	טטט	01411			11dy 10, /	2000	
			Mahesh Krishnamoo	rthy 11110		Campı	ıs R	d, Ste	e. 150	O, Hage	rstown, 1	MD 21742	
t s	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4 20	106 Seem	-	este							

		1 - For State Registrar		Ce.	rtificate of			g. No.			
Physici /Medic		Decedent's Name (First, Middle, Arthur Blain	e Richards, Jr				2. Date of Death Month May	Day 18 &		of Death 5 A M	
Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County	of Death		
Funeral		5. Social Security Number	11X1M 2□ F	Vra	If Under 1 Year Months Days	gerstown If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	ngton Col 9. Birthplace (Sta Country)	te or Foreign	
Director		214-34-9798 Usual Residence of Decedent	67	1 115.			Sept 28	1938	Maryland	<u></u>	
ene. than "natural", or items 23a or 28a-f show he Modical Examinat must be notified at		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside	City Limits	
4 E	ξ	Maryland Washington Hagerstown							101	es 2No	
r 28a	Director	10e. Street and Number	<u> </u>		10f. Zip Code		10	g. Citizen of W	hat Country?		
Sa o at ba		13136 Fountainh	ead Road		2	1742		U.	S.A.		
"nsturs!", or itsms 23a or 28a-1 show colcal Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, No 1 ☐ Yes 2 No Specify:				s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White			
and H		15. Decedent's		16a, Dece	dent's Usual Occup	pation	1	6b. Kind of Bu	siness/Industry		
	Completed	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of work	ring	00. 11110 0. 00			
릞	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Г	ravel Ag	ency		0	wner		
d other then event, the M	BeC	17. Father's Name (First, Middle, La	st)				e (First, Middle, M	aiden Sumam	9)		
ic sy	ToB	Arthur Blaine F	cichards, Sr.			Evelyn	Shacklefo	ord Ric	hards		
item 27 is marked other trsumatic sv		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailii	ng Address (Street	and Number or Rur	al Route Number,	City or Town, :	State, Zip Code)		
27 ls		Connie Richard	ls (wife)	1313	6 Founta	inhead Ro	ad Hagers	stown M	aryland:	21742	
othe		20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other plac	cel	Date 2	0c. Location -	City or Town, State		
יז מ יץ פי		12 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				ery May	22 06 I	Hagerst	own Mary	land	
Important: If the sany injury or concept		21 Su ature of Funeral Service Lic		22	2. Name and Addre	ss of Facility Do	uglas A.	Fierv	Funeral I	Tome	
eny ir	1	1) courtes	No True			ern Blvd.					
sician edical miner		23a. Part1. Enter the disease, or or shock, or heart diverse. List or immediate Cause (Final disease or condition resulting in death)	ly one cause be each line.	dekin	, ly my				Interval I Onset ar	Between and Death	
pnysicien and s the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons								
physic the b	Aedical		d						D		
been signed by the attending p should be deteched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes \ 2 \] No 9 \[Unknown \] 23c. If yes, outcome of pregnancy 1 \[Live birth \ 2 \] Fetal death 4 \[Pregnant at time of death 9 \] 4 \[Pregnant at time of death 9 \] 9 \[Unknown \] 23c. If yes, outcome of pregnancy 3 \[Ectopic pregnancy 5 \] 6 \[Other (specify) \] 9 \[Unknown \]							23d. Date of delivery Month Day Year		
uld be dete	þ	Part II. Other significant conditions								cco use contribute to the cause of death?	
page 2	Completed						24a. Was an autopsy perform	ed? pi	Vere autopsy finding to completion of eath?	gs available f cause of	
is certificate director, pag	Be	25. Was case referred to medical examiner?					h Check only one				
w 75	은	1 ☐ Yes 2 ☐ No	And the second second	☐ ER/Outpatier		4 Nursing Ho	me 5 ☐ Residen				
Arter	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	bo -		M 1□	yat k? Yes 2 □ No	28d. Describe hov	injury occurre	d		
To the Funeral Director: completely filled in by the		4 Homicide determine	building, etc. (Spe	cify)			City or Town,	State)	r or Rural Route N	umber,	
To the Funeral Di	Medicai	one) 2 Medical Ex	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nowledge, death nation and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, a	nd due to the cause		
To	2	29b. Signature and title of certifier	Mularm	(m)	29c. Licens	e number 41667 Arcd		-	(Month, Day, Year		
		30. Name and address of person wt	o completed cause of death (It	em 23a) (Type,	Print)	/	/	11			

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 2 3 2006 Leven J.

		•	For State Registrer 1. Decedent's Name (First, Middle, Last,	State of Maryla	•	artment of rtificate of			Reg. No. 200	6 1732 3. Time of Death_	
	Physicia /Medic Examin	al	George William Ro 4a. Fecility Name (If not institution, give	ach, Jr.		4b. City, Town,	, or Location o	Month	20 200 4c. County of De	16 1302 PM	
	Funeral		Washington County 5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	Hagers If Under 1 Yea Months Day	r ff Under 2	8. Date of Bird Min. (Month, Da 08/06/1	Washing 9. E	ton Birthpface (State or Foreign Country)	
9	Director		Usual Residence of Decedent	X M 2□ F	85 Yrs.		3 110013	08/06/1	1920	MD 10d. Inside City Limits	
не Магуіа	8a-f ehov	Director	MD Washingt		Hagers	town			10g. Citizen of What	1 XYes 2 ☐ No	
ith with t	23a or 2 uni be n	rai Dir	319 Bryan Place 21740 US								
urs after dea	er, or itame Exeminer m	by Fune	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 N		gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White	
ind jail 2 (2.12.15-0000) and jail jail jail jail jail jail ja jail jail	Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show important: if item 27 is marked other then "neturel", or items 23a or 28a-f show yinjury or other traumatic event, the Medical Exeminer must be notified at once.	Completed by Funeral	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12) 1.2	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most red)		16b. Kind of Business/Industry City		
y ican w	Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) George William Roach, Sr. 18. Mother's Name (First, Middle, Main Ella (unk) Hunsh						nsberger		
and 2 sho	eaith and n 27 is m ser traum		Janet Grossnickle	(Daughter)	6559	Ridge La		r or Rural Route Numberightsville	, PA 17368		
Dallillore, permit. Pages 1 a	tment of H tant: If ite jury or oth		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	Rest Hav	en Cemet	tery C	Date 05/24/2006	Hagerstow	n, MD	
2 eg	Departimpor any in		21. Signature of Funeral Service Licens	888				Gerald N. Street, Hag		uneral Home MD 21740	
	ysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cone cause on each line. a					rrest,	Approximate Interval Between Onset and Death	
	Medical caminer			b. Strok	ke					1hr	
ecuted	ind transit	Examiner	5 squartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Attwocless 5 Due to (or as a consequence of):							years	
cate be executed	physicien end s the burial-transit	edical E		d. Hyjre	itens/m					years	
nat the death certifica	the ettending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant al time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnar □ Other (specify)			23d. Date of o Month	delivery Day Year	
he law requires that the	been signed by should be detec	þ	Part II. Other significant conditions co	entributing to death but not	. •	, ,	given in Part I.		obacco use contribute	to the cause of death? Probably 4 Unknown	
5 2	ete has page 2	e Completed	Of Manager stands to region				00.01	1 ☐ Yes	psy prior t primed? death 200 No 1 1 Y		
OI VILA Physician:	is certifice director. p	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 X ER/Outpatie	nt 3 DOA	Ther	of Death Check only of rsing Home 5 ☐ Residual		pecify)	
JOY Attending Physician:	eath. or: After he fune	Certification: 7									
DIVI pital or Att	at in in		4 Homicide determined	building, etc. (Sp	pecify)			City or To			
I the Hospitai	F.E.	ledical	(Check only 2 Medical Exemone)	ysician: To the best of my iner: On the basis of exan and manner stated.	mination and/or in	vestigation, in m	y opinion, deal	th occurred at the time,	date and place, and d	lue to the cause(s)	
To the	5	×	30. Name and address of person who could be seen and address of person and address of person and address of person and address of person address of person and address of person address of person and address of person address			29c. Lice	D 449	96	May 2/	, 2006	
10) * (30. Name and address of person who could be seen and address of person who could be seen as a seen and address of person who could be seen as a seen and address of person who could be seen as a seen and address of person who could be seen as a se	completed cause of death	(Item 23a) (Type	Sappan,	s Rd	Beonston	0 MD 2	17/3	
H	St	ate	31. Date filed (Month, Day, Year)	32. Segistrar's S	ignature	artes					

RCHay, GEONGE WILLIAM

State of Maryland / Department of Health and Mental Hygiene 1732

					Certificate	of Death	Re	eg. No.	00	11029			
Diversi		1. Decedent's Name (First, Midd					2. Date of Deat Month	Day	Year	3. Time of Death			
Physi /Med		James	William		enson	Jr.	May 24			8:55am			
Exam		4a Facility Name (If not institutio					Locetion of Death	4c. County					
<i>(</i>		Devlin Manor N	ursing Home			Cumber			Allega				
Funera Directo		5. Social Security Number 214-28-6703	6. Sex 7. / 1 M 2 □ F	Age (In yrs. last l 75	oirthday) If Under 1 Months	Year If Under 24 Hrs Days Hours Min		^{Year)} 1931		ace (State or Foreign ID			
P >		Usual Residence of Decedent 10a. State 10b. County		10c City To	wn or Location				10	Od. Inside City Limits			
e Maryla Ba-f shov	ctor	MD Alleg			umberland					1∏ Yes 2□ No			
th with th 23a or 28 ust be no	ral Dire	10e. Street and Number 12914 Sixth Ave			10f. Zip C	21502		0g. Citizen of V	SA				
5-0020 72 hours after death with the Maryland natural", or Itema 23a or 28a-1 show digal Examiner must be notified at	Completed by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorced	If Yes, Give	s?] No Koroa	13. Was Decede If Yes, specif	nt of Hispanic Origin? (3 y Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	Blac	e - America ck, White, e	etc.			
in 72 hours n "natural", Adical Ex	pleted	(Specify only highe	nt's Education est grade completed)		a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of wo retired)	orking	16b. Kind of Bu	usiness/Ind	lustry			
d 2121 filed within Hygiene. ther than ont, the We	E	Elementary/Secondary (0-12)	College (1-40	1 5+)	laborer			Chess	ie Sys	stem			
land 2	To Be C	17. Father's Name (First, Middle, James Williar	•	, Sr.			me (First, Middle, M Beatrice L			enson			
Marylar Ma Should b M 2 should b Ith and Menta 7 Is marked traumatic or	Ĕ	19a. Informant's Name/Relation. Perry Stevensor	ship (Type, Print) SON	1:	9b. Mailing Address (Street and Number or F	Rural Route Number Essex	, City or Town,	State, Zip	^{Code)} 21221			
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental hygiene. mportant: If item 27 is marked other than "natural", or my injury or other traumatic event, the Medical Examinating the properties of th		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		20b. Place ceme Hillcre	of Disposition (Name tery, crematory or oth est Memorial	e of eer place) Park		20c. Location - Cumbe	•	wn, State			
Baltimo permit. Page Department of Important: If any Injury or	- BOCE	21. Signature of Funeral Service	Licensed	111		pellî Funeral H Virginia Avenu		and, MD 2	21502				
Physicia		23a. Party Enter the disease, or combitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
/Medica	al .	Immediate Cause (Final disease or condition resulting in death)	a	Hepat	a consequence of):	Concern	ne`			lyn			
	ē			Due to (or as	a consequence or).				1				
uted day	듵	Company that are able to	b	Due to (or as	a consequence of):								
), exec n an	Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	,	2000000					i				
x 68760, ertificate be executed ling physician and eas the burial-transit	Medical Examiner	that initiated events	С	Due to (or as	a consequence of):								
600 Hificat g phy as th	B	resulting in death) Last											
Box sath cert attending for use	3		d							.,,-			
BO)	icia	Part II. Other significent conditi	ons contributing to death	but not resulting	in the underlying ca	use given in Part I.	23b. Did to	bacco use co	ntribute to	the ceuse of death?			
IS, P.O. I res that the des igned by the a be detached f	Physician	Tarin. Other algriniothic ochical	one contributing to coun		,	-	1 🗆 Y	es 2 □N o	3 🗆 Prob	oably 4 □ Unknow			
COTC requir been s should	Completed by						24a. Was a perfori		ava	ere autopsy findings ailable prior to appletion of cause death?			
Re law has ge 2	ф						1 🗆 Y	es 2 No	1.]Yes 2□No			
		on Western desired				OC Plans of D							
of Vital Re Physician: The I this certificate ha	Be	25. Was case referred to medical examiner?	Hospital:			Other:	eath (Check only or		or (Cassif				
	.T	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a, Date of I		Outpatient 3 DO/ D. Time of 28		Home 5 ☐ Reside			//			
Vision Attending For death. ector: After by the funer	ation	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Month, tigation	Day Year)	Injury M	c. Injury et Work? 1 ☐ Yes 2 ☐ No							
Division of Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could deten	mined 200. Flaue of	Injury - At home, etc. (Specify)	farm, street, factory,	office	28f. Location (Si City or Town	treet and Numb n, State)	oer or Rura	I Route Number,			
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifyl (Check only one) 2 Medica	ng Physician: To the be I Examiner: On the basis and manner	of examination	lge, death occurred a and/or investigation,	t the time, date and place in my opinion, death occ	ce, and due to the courred at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)			
of the office of	Me	29b. Signature and title of certifi	θr			License number	,	9d. Date signe					
F \$ F 0		► 832e	Un To W		7	001756		may ?	14, 2	606			
6		30. Name and address of person	000 922	of death (Item 23	e) (Type, Print)	LaUble	11 2	150 -					
	State	31. Date filed (Month, Day, Yea	32. Reg	strar's Signature	marks)					r			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Ronelda Romaine Sapp 25th, 2006 May, 10:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 9. Birthplace (State or Foreign Memorial Hospital Cumberland
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours 1 ☐ M 2 ☐ F Jul 23, 1917 214-07-6658 88 Yrs Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Madical Examiner must be notified at MD Allegany Cumberland Funeral Director 1√ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 19 Humbird Street 21502 USA 238 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or itama 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3X Widowed 4 ☐ Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any linjury or other treumatic event obes. Be Hilda Brady May Scott May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,
19 Humbird Street Cumberland N 19a. Informant's Name/Relationship (Type, Print) nte, Zip Code) MD 21502 daughter Garie Deremer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 5/26/2006 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral S 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inler the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one can see an each line. Approximate Interval Between stock/or heart failu Immediate/Cause (Final disease or condition resulting in death) Onset and Death Physician MIREKS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed use as the buriel-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the attend a detached for us 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 BNo Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

_1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 's effer dean...
rel Director: Affer this cer....
rin by the funeral director, pr 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 ☐ Homicide within 24 hours e To the Funsrel C TEC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D14865 four wand 26

State Registrar DHMH 17 Rev 1/2001

01

500 Memorial Ave. Cumberland, MD 21502

uner

M.D.

32. Registrar's Şignature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano J.Barrera,

31. Date filed (Month, Day, Year)
JUN 0 1 2006

2006

06-03484 Patrick Stewart

Please Type or Print in Black Indelible Ink

Physic	ian	1- For State Registrar 1. Decedent's Nar		otate of Mai	yiano / L	Certifica	te of	Health and Death	d Mer	ntal Hy ——		Reg No	20	106	70
Medical Exan				Stewart							Date of De Month		Year	3 T	ime of Death
		4a. Facility Name	(if not institut	tion, give street an	d number)		4t	. City, Town, or	Location	of Death	Month May 22,	2006	County of [603 hrs
		445 Dirk A						Cumberland					llegany	Jeath	
Funera Directo		5 Social Security		6. Sex		yrs last birth	day)	If Under 1 Year	_	er 24Hrs.	8. Date of B		DD/YYYY) 9	Birthplac	ce (State or
		220-80-20		1 XM 2	F	46	Yrs.	Months Days	Hour	s Min.	6-21-	-1959	F	oreign Country)	MD
, and		Usual Residence	10b. County	,	100	c. City, Town or	Location								
ind show ace.	١	MD	Alle	egany	j	,,		nberland	1						Inside City Limits
Marylz 28a-f dator	Director	10e. Street and Nu						Of. Zip Code				10a Citizi	en of What	^*	Yes 2 No
th the	ā	24 Mass	sachuse	etts Aver	nue			215	502				on or virial		C A
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene 'item 27 is marked other than "natural", or items 23a or 28a-f show any r traumatic event, the Medical Examiner must be notified at once.	Funeral	11 Marital Status	ied 2 N		Decedent Eve d Forces?	r in U.S 1	3. Was I	Decedent of Hisp	anic Orig	gin? (Spec	cify Yes or No	0- 1	4 Race - A	merican In	SA Idian, Black,
ter dez] <u>-</u>			1 Ye vorced If Yes, Give	s 2 x	No		specify Cuban,		, Puerto Ri	ican, etc.)		White, et	C.	
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Baltimore, ME permit Pages I and 2 s Department of Health as Important: If item 27 injury or other traums	,	21. Signature of Fu	peral Service	Licersee	11/1	, _	22. Nam	e and Address o	f Facility	Scarp	<u>/2000</u>	unar	esapt	own,	MD
Physician	-	2/3a I I Enter th	e disease or	c Prolice France tha	VVV									D 215	502
/Medical								node of dying, su	uch as ca	rdiac or re	spiratory arre	est, shock	, or heart	Appr Bety	oximate Interval veen Onset and
Examiner		Immediate Cause (i or condition resultin	Final disease ng in death)		s a consequen		ad								Death
*****	L	Sequentially list cor		b											
	nine	if any, leading to im cause Enter Under	rlying Cause	Due to (or as	a consequen	ce of):									
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Reco	m o									-	autopsy perform	y ned?	prior to death?	completio	n of cause of
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Physic Physic rthis c	To B	1 Y Yes 2		Hospital: 1	Inpatient 2	ER/Outpat	ient 3	DOA Oth	er 🖂	lursing Ho		esidence	6 V Oth	er: Scene	
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28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or or Town, State) 445 Dirk Avenue, Cumberla											Number, City				
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Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:		one) 2 V M	ledical Exam	vsician: To the be iner:On the basis and manner:	oi examinatio	n and/or invest	igation, ir	i trie time, date a i my opinion, dea	ind place ath occur	, and due t red at the	to the cause(: time, date an	s) and ma d place, a	anner as sta and due to ti	rted ne cause(s	3)
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6		30. Name and addres Ana Rubio MI													
	te ³	31. Date filed (Month,		stant Medical	egistrar's Sign		Stree	t, Baltimore,	MD 21	201					
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State of Maryland / Department of Health and Mental Hygiene) For Stata Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death May 14, **Physician** Year 2006 Joel Lawrence STEIN 11:30 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care of Silver Spring Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | OCT . | 29 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Year 1940 1√2 M 2□ F 65 Yrs. 089-32-6959 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23a or 28e-f show the Medical Examinar west be notified at 1 ☐ Yes 2 ☑ No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Cannon Road 20904 United States perrit. Pages 1 and 2 should be filled within 72 hours after death a Department of Health and Mental Hygiene. Importent: if frem 27 is marked other then "neturel", or frems 23 any njury or other treumstic event, the Medical Example in the standard of the medical Example. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 € No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 2 white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Computer Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herman Stein Mildred Krakower ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Cannon Road, Silver Spring, MD Sandra Stein, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Shaare Tefila Cemetery 05/16/06 Adelphi, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 4 Weeks /Medical Due to (or as a consequence of): **Examiner** 1 Neek Prieumon fa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the buriaf-transit that initiated events resulting in death) Last Failure to Thrive Months Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the a þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Sacral Decubitus Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Huntington's Chorea certificate 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification; To 2 ER/Outpatient 3 DOA S 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 🖾 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 Homicide 29a. Certifier 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 15, 2006 1411 D 19609 auran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, Suite 202, Gaithersburg, MD Raman R. Tuli, M.D., 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Serena. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11, per f.home, 5/2206, E. Gertificate of Death WCHD Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year 6126 AM Car Tohn Daunders 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner costal Hospice At the Lake Selisbury WICOMICO If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) 5/18/1952 Funeral 9. Birthplace (State or Foreign Days Hours Min 1 XM 2 □ F Months Yrs. Puerto Rico Director 217-60-8816 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 No Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2209 N. Philadelphia Ave #109 items 23s 21842 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ed 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental h 2 Jasper D. Saunders, Sr. June Elizabeth Postle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If item 27 is any injury or other tra 2209 N. Philadelphia Ave., #109, Ocean City, June E. Saunders 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 5/19/2006 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enterente disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one coust on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts. Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ettending physician of for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 🗆 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes patient 2**5**.No Medical Certification: To 2 ER/Outpatient 3 DOA After thi 27. Manner of Death

Natural

Control

Control ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapped stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number

State Registrar Countly, MD

MAY 1 9 2006

31. Date filed (Month, Day, Year)

Po Box 1733 Solish, MD

			State of Marylan			_	•
		1 - For State Registrar	•	Certific	ate of Death		Reg. No. 2006 17329
Physic /Med		1. Decedent's Name (First, Middle, Las	M. SLZS	EKER			13, 2006 2:02P ^M
Exami	iner	4a. Facility Name (If not institution, give			City, Town, or Location of De	eath	4c. County of Death
Funera		ANNE ARUNDEL MED 5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If U	NAPOLIS nder 1 Year If Under 24 F ths Days Hours M	Hrs. 8. Date of Bir lin. (Month, Da	th 9. Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	M 2□F 91	Yrs.		MAR.07	,1915 ARKANSAS
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er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	b- 14. Race - American Indian, Black, White, etc.
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12 sho	4	19a. Informant's Name/Relationship (7	21				er, City or Town, State, Zip Code)
permit. Pages 1 and 2 Department of Health s Important: If Itam 27 is eny injury or other tra		ELIZABETH A. SLEEP 20a. Method of Disposition	20b. I	Place of Disposition	Y FRONT DRIVE	E #216 Al Date	NNAPOLIS MD 21403 20c. Location - City or Town, State
mit. Pages 1a partment of Hei portant: If Itam y injury or otha		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crematory LINGTON N		-26-06	ARLINGTON VA.
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Physiciar /Medica Examine	ı	shock, or heart faifure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.		faction millation		Interval Between Onset and Death
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Hospital 24 hours a Funeral stely filled	edical						cause(s) and manner as stated. date and place, and due to the cause(s)
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	-	State Registrar				Cei	rtifica	te of L	Death		/lental	Reg	. No.	06	1733
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kamine		4a. Facility Name (If not institution	on, give stree	et and num	ber)		4b. City	, Town, or	Location	of Death			4c. Cou	inty of Dea	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** Toold 05 10:30 PM 2006 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Wicomico Hospital Solisbur Head If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K) F 83 9/25/1922 Yrs 214-12-5945 Director Maryland Usual Residence of Decedent Peges 1 end 2 should be filled within 72 hours efter death with the Merylend nent of Heatth end Mental Hygiene.
Int: If item 27 ie marked other than "naturel", or items 23e or 28e-f ehow Iry or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 9288 Hickory Mill Road 21801 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery 12 Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Orlie Brinsfield Jones Nellie Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Fields/daughter 216 Spring Crest Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition permit. Pages 'Depertment of H important: If its eny injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 5/19/06 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee THOTTOWAY TUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 buil of. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Physician/Medical Examiner weeks to nding physicien end use es the buriel-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Artery edical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1LI Yes ours efter deeth.

•rai Director: After this certifice filled in by the funerel director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ole Pong Japan. Staff Physician 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Doo<u>63368</u> 35 DONG HYUN LEE Deer, Hand Road Salabun M.P 31. Date filed (Moath, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			Amend Items 23a	, 23, 21, 200	per	Certifi	Zate 3f	20/06dhl	b	Reg. No. 2	106	11336
	Physici	ian	Decedent's Name (First, Middle, Land)		- 11 -	+			2. Date of De Month	Day	Year	3. Tima of Death
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1	Examir	ner	FutureCare- Loche				'	Balti	r Location of Death		y of Death N/A	
	Funeral	Г			e (In yrs. last i		Jnder 1 Year	If Under 24 H	rs. 8. Date of Bir			e (State or Foreign
	Director		212-22-0559	I□M 2∏F	80	Yrs. Moi	nths Days	Hours Mi	n. (Month, Da Nov. 1	y, Year) 3 . 1925	Mary	e (State or Foreign) land
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c City To	wn or Location						
	Maryl.	ō	Maryland N/	A	,		Baltim	ore			100.	Inside City Limits XXYes 2 □ No
	r 28s	rec	10e. Street and Number				f. Zip Code			10g. Citizen of	What Country	?
	ter death with the Marylan Items 23a or 28e-f ehow Iner must be notitited at	by Funeral Director	4800 Seton Drive					21215				USA
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was D	Decedent of H	ispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Rac	ce - American ck, White, etc.	
20	s afte	y Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2X X If Yes, Give	No		es 2010		, , , , , , , , ,	Specif		
ခု	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow he Modical Examinet must be notified at	8	15. Decedent's E	Year or Dates:	16	a Decedent's	Usual Occupa	ation		16b. Kind of B	whi	
215	hin 7:	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	(A)	(Give kind o life. DO No	of work done of OT use retired	ation during most of w f)	rorking	TOD. KING OF B	usii less/ii luusi	uy
21	ed wit	Com	8th	College (1-401)	,+,	Hoste	ss			Colleg	ge Cafe	eteria
ng	be file d oth	Be	17. Father's Name (First, Middle, Last, Frank Lazzaro						ame (First, Middle,	Maiden Suman	ne)	
<u> </u>	hould d Mer nerke	၉							Culotta			
Ma	treum		J. Michael Hollow						Ru <i>ral Route N</i> umbe Suite 54			
re,	s 1 ar f Hea ftern other		20a. Method of Disposition		20b. Place	of Disposition	(Name of		Date	20c. Location -		
E E	Pages nent of I int: If ite		X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Garde	ery, crematory ens of	Faith	emeter	y 2/17/06	Fulle	erton,	Maryland
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Martal Hygiene. Important: If item 27 is marked other than "naturei', or any injury or other treumetic event, the Modical Exampone.		21. Signature of Feneral Service Licen	See /		22. Nam	e and Addres	s of Facility	T ² 1	11 7		
ш	20 F # 9		Y Janu Ho	put		3631	e-nens Falls	S-Seitz Road B	Funeral altimore,	Maryla	nc. ind 21	211
П.		=	23a. Part1. Enter the disease, or com shock, or heart failure. List only	oldations that caused	the death. Do	not enter the	mode of dying	g, such as cardia	ac or respiratory ar	rest,	Ap	proximate erval Between
)	Physician /Medical				Subdur	al Hep	atoma '	with co	mplication	ns	On	set and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)	a	= =	sep q	- frose	Homey	(1)		8	वेक्षु ड
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<u> </u>	E # :: 0	()	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.			ctory, office		28f. Location (Si	reet and Number	er or Rural Ro	ute Number,
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	Physici /Medic		Decedent's Name (First, Middle, Last) NORMAN I	THOMAS			2. Date of Death Month May	Day 12,2006	3. Time of Death 22:34 M
	Examin		4a. Facility Name (If not institution, give st Valencia Motel	reet and number)		wn, or Location of Deat aurel	h	4c. County of Deat Howard	h
	Funeral Director		5. Social Security Number 6. Sex 212-54-9006 1 □ 1 □ 1 □ 1	% 2□F 7. Age (In yrs. last birthda 56 Yrs	Months [Year If Under 24 Hrs Days Hours Min.		, 1950 M	hplace (State or Foreign ountry) aryland
	death with the Maryland ime 23s or 28s-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County MD Prince (10e. Street and Number	George Laur	_	ode	10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ ¥6s 2 ☐ No
		by Funeral D	9000 Briarci 11. Marital Status 1 \$\infty\$Never Married 2 \(\text{Married} \) Married 3 \(\text{Widowed} \) 4 \(\text{Divorced} \)			0708 t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - Ame Black, White	
21213-0030	d within 72 hours after giene. or then "natural", or ite i the Medical Examilia	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	ation 16a. De (G (G (iil)) College (1-4or 5+)		Occupation done during most of wo retired) Of Anima	rking	6b. Kind of Business/	Industry
אוומ /	uid be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Norman M. Th	nomas Sr			ne (First, Middle, M na L. Gi		
baltimore, mary	permit. Pages 1 and 2 should be filed within 7 Department of Health and Marail Hygiens. Important: if I tem 27 is marked other then "n any injury or other fraumatic event, the Mad once.		19a. Informant's Name/Relationship (Typ Lena L. Thomas— 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Senature of Funeral Service Licenses	MOther 900 20b. Place of Discembery, Commoval from State MD Nat	0 Bria sposition (Name rematory or other ional 22. Name and	Park 5/1	ne Laur Date 2 .9/06 nowden	el, MD 2 Oc. Location - City or Laurel, Funeral	0708 Town, State
	icate be executed TS Permit. Physicien and WS C Depart Import s the burial-transit and process.	edical Examiner	23a. Pant1. Enter the disease or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ations that caused the death. Do not a cause on each line. MYOCARDIAL I Due to (or as a consequence of): CORONARY HEA Due to (or as a consequence of): CHRONIC OBST Due to (or as a consequence of):	NFARCT	ION			Approximate Interval Between Onset and Death
YOU .	death certii e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregi 5 □ Other (speci			23d. Date of deli Month	very Day Year
ecords, r	requires that the een signed by th nould be detache	þ	Part II. Othar significant conditions cont Asthma	ributing to death but not resulting in the	underlying caus	se given in Part I.		acco use contribute to	the cause of death? obably 4 <u>M</u> Unknown
_	The la	Completed					24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
VICA	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:		104	ath Check only one		Moto 1
5	nding Phys th. : After this e funeral di	 -	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		Injury at Work? 1 Yes 2 No	ome 5 ☐ Residen 28d. Describe hov	nce 6 N ther (Spec v injury occurred	Motel
DIVISION	s after des s after des al Director ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, o	ffice	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Alter it completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 □ Certifying Physical Examination (Check only one)	cian: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	ath occurred at investigation, in	he time, date and place my opinion, death occu	e, and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	3 within	Σ	29b. Signature and title of certifier	Holon	D	19923	29	d. Date signed (Mohith	Day, Yearl,
			30. Name and address of person who con Marie Amos Do 31. Date filed (Month, Day, Year)	byns 7350 Van I 32. Registrar's Signature	ousen #	320 Laure	el, MD 2	0707	
-34	Sta 		WEV 1 7 70	108 September 2019	freels.				

			1 - State Registrar	State of t	viaiyiaii	-	rtificate			and iv	тептат пу	Reg. No.	2000	1/339
	Physici	an	Decedent's Name (First, Middle, La								2. Date of De Month	Day	Year	3. Time of Death
	/Medi	cal	Brenda Tinsm				-				May	19,		9:45 A ^M
1	Examir	er	4a. Facility Name (If not institution, giver Frederick Metalog)			+ - 1	,		Location o				County of Death	
1000	Funeral	40	5. Social Security Number 6.5		Age (In yrs. I		If Under		If Under		8. Date of Bir	i	reder	LCK place (State or Foreign
	Director			□M XXXF	55	Yrs.	Months	Days	Hours	Min.	8. Date of Bir JULY 17	1950	WEST	VIRGINIA
	P .		Usual Residence of Decedent											
	e Marylar Sa-f ehow	Director	WV BERKEL	EY	10c. City	, Town or Lo	ESVIL	LE						10d. Inside City Limits 1 Tyes 2 No
	ath with th	ral Dire	10e. Street and Number 1895 PALMER ROA	D			10f. Zip	25	427			U	sen of What Cou	intry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Itema 23a or 28a-f show other traumatic event. Ite Madical Exertings marks notified at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	ss? X No		Was Deced fYes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White Specify: WH	
2-0	72 hc	etec	15. Decedent's E (Specify only highest gra	fucation de completed)		16a. Deced	ient's Usua kind of wor	l Occupa	tion urina most	of work	ina		d of Business/Ir	ndustry
21215-0036	filed within Hygiene. ther than int. Its Ma	Completed	Elementary/Secondary (0-12)	College (4-4	or 5+)	I N V	ESTIC	ATOF	}				I CORP NCIAL)	
Maryland	outd be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last, JAMES EVERHART								WILLOU		Sumame)	
	and 2 sho salth and n 27 le ma		19a. Informant's Name/Relationship (DOUGLAS P. TINSM			1895	PALM	ER F					Town, State, Zi, V 25427	p Code)
Baltimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 1X78urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			lace of Dispo ametery, cren E HILL (natory or of	h <i>er pl</i> ace) M	AY 23,	2006		RLES TOWN	
Balti	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service-Licer	1. Br	42		Name and				OWN FUNEI NSBURG, 1		ME, P.O. 02	BOX 821,
15	¥.		23a. Part1. Enter the disease, or com shock, or heart failure. List onty	plications that caus	sed the death	. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. V7 -	as a consequ			0-	, 5	500	all	cel	~	Onset and Death
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68760,	tificate be executed ig physicien and as the burial-transit	edical Ex	resulting in death) Last	Due to (or	as a consequ	ience of):								
O. Box 6	death cer e attendir ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/nths? 1 ☐ Yes 2 No 9 ☐ Unknown		i 2 ∏ Fetal tat time of de	death 3	Ectopic pre					23	3d. Date of deliv Month	ery Day Year
S, P	98	ρ	Part II. Other significant conditions of			-		_			•			he cause of death?
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Record	The law ate has b page 2 s	Completed									24a. Was autor perfo		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	H-sale to the sale				1-		of Death	Check only o	-		
of o	Physi this c al dire	2	1 Yes 2 No	Hospital:		ER/Outpatien		-	4 🗀 1401				Other (Special	5)
Division	Attending F r death. ector: After by the funera	atlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		njury Day Year)	28b. Time of Injury	M 28	c. Injury Work 1 🗆 Y	at ? es 2 ☐ N		28d. Describe I	now injury	occurred	
Divi	# # # E	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	Injury - At hor etc. (Specify	me, farm, stre	eet, factory,	office			28f. Location (; City or Tox		Number or Rura	al Route Number,
	승규가 원	edical	29a. Certifier (Check only one) Check only one)	ysician: To the be niner: On the basis and manner	s of examinati	wledge, death ion and/or inv	occurred a estigation,	t the time	a, date and inion, deat	l place, a	and due to the ed at the time,	cause(s) a date and p	and manner as s place, and due to	tated. o the cause(s)
	To the within 2. To the complet	Ň	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Month,	Day, Year)

State Registrar

29c. License number

son who completed cause of death (Item 23a) (Type, Print)

			For State	State of M	laryland / Depa Ce	artment of H <i>rtificate of L</i>			ne 2 () ()	6 17335
			Registrer 1. Decedent's Name (First, Middle, Last)		Timodio or E		2. Date of Death		3. Time of Death
	Physicia		J. D. TAYLOR Sr.					Month a	Day ZOO	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death		4c. County of De	-
			Washington County	y Hospita	.1	Hage	erstown		Washin	igton
F	Funeral Director		5. Social Security Number 6. Se 219-20-1404	X 7. A	ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y April 16	ear) (Sirthplace (State or Foreign Country) Maryland
	2		Usual Residence of Decedent		10.00 7					10d. Inside City Limits
	anylan show	_	10a. State 10b. County		10c. City, Town or Le					1 ☐ Yes 2X No
	788-f	ecto	Maryland Washing	ton	паде	rstown 10f. Zip Code		100	. Citizen of What (
	3a or	10	20411 Leitersburg	Pike		101. 2.0 0000	21742	.09	USA	oodhay.
2	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. In a marked other then "natural", or items 23a or 28a-f show umatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 ☐ If Yes, Give	No	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☒ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh Specify:	merican Indian, hite, etc. white
	72 hour natural	Completed b	15. Decedent's Edi (Specify only highest grad	Year or Dates: location le completed)	16a, Dece	dent's Usual Occupa kind of work done of DO NOT use retired,	ation furing most of work	king 16	b. Kind of Busines	ss/Industry
7	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or		ck driver	,		eight tr	ansportation
3	filed Hygi other ent, I	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma		
<u> </u>	uld be Jenta rked tic ev	To B	Carl Victor Tay	lor			Leona	Lucinda I	homas	
_	permit. Pages 1 and 2 should be filed within Department of Health and Mahall Hygiene important: if item 27 is marked other then eny injury or other treumatic event, the Magnes.	•	19a. Informant's Name/Relationship (T			ng Address <i>(Str</i> eeta 11 Leiters				
ע	of He		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other place			c. Location - City	
	Pages tment of l tant: If it		4 ☐ Donation 5 ☐ Other (Specify,		Rose Hill	Cemetery				n, Maryland
<u>8</u>	permit. Depertr Imports eny inju		21. Signature of Femeral Service Licens	m	/ /	2. Name and Addres $15~{ m E.}~{ m Wil}$		INNICH FU		
			23a. Part1. Enter the disease, or comp	lications that cause	ed the death. Do not en					Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	ALI		1/	0	۸.		Interval Between Onset and Death
/.	/Medical		disease or condition resulting in death)		s a consequence of):	aonay Ve	sculer	UI Steak		
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	ed sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):					
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9	e be e	dical E		d						
0	tificat ig phy as the									
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funstel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	delivery Day Year
ŗ	that the bod by detact		Part II. Other significant conditions co	ntributing to death	but not resulting in the t	inderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
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č	The litte he	E						autopsy performe	death'	o completion of cause of ? es 2 No
159	ian: prtifica ctor, I	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	-	
> 5	hysic his ce I dire	2	Yes 2 No	Hospital: 1 🗌 Inpat			4 Nursing n	ome 5 Resident	e 6 Other (Sp	pecify)
<u> </u>	ing P	on:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of In (Month, D	ury 28b. Time of Injury	Work		28d. Describe how	injury occurred	
VISION	ttend death stor: / the f	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of Ir	njury - At home, farm, st		Yes 2 □No	28f Location /Stre	et and Number or	Rural Route Number,
2	after after Direct	Certification:	4 Homicide determined		etc. (Specify)	real, factory, office		City or Town,		1818 1888 1888
	Hospita 24 hours Funerel etely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the besiner: On the basis and manners	t of my knowledge, dea of examination and/or in stated.	th occurred at the time	ne, date and place pinion, death occu	, and due to the cau rred at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
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,			30. Name and address of person who o	1 - 0		Print)		11		0.41
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Edward IRITAPOE 137 AM 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Med. CIR Baltmore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☑ M 2 🗆 F 81 215-20-9459 1924 JUNE 1. MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND WASHINGTON KNOXVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19511 GARRETTS MILL ROAD 21758 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HEAVY EQUIPMENT OPERATOR STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CALVIN T. TRITAPOE SR. RHODA E. YOUNKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE L. TRITAPOE/SPOUSE 19511 GARRETTS MILL_ROAD, KNOXVILLE, MARYLAND 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donati 5 Other (Spee BROWNSVILLE HGTS. CEM 5/19/2006 BROWNSVILLE, MARYLAND re of F 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner?... 26. Place of Death (Check only one) npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be

burial-transit Division of Vital Records, P.O. Box 68760, the attending physician the dot for use as the buria death.

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

"naturel", or Iteme 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na ery Injury or other traumatic event, The Madis once.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Certification:

3 Suicide

29a, Certifier

29b. Signature

4 T Homicide

Baltimore, Maryland 21215-0036

State Registrar

determined

itle of certifier

and manner stated.

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed, (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		Please	State of Ma					•	•	е.
		1 _ State	State of Ma	-		ate of Deat			200	6 17337
		Registrar 1. Decedent's Name (First, Middle, Li	astl		Certifica	ile oi Deal		2. Date of Death	No.L. U U	3. Time of Death
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/Medic Examir		4a. Facility Name (If not institution, gi		<u>- </u>	4b. Cit	ty, Town, or Locatio	on of Death	Tidy	4c. County of E	
LAdiiii	iei	7671 Fairbanks	Court			Hanover			Ann	e Arundel
Funeral		Social Security Number 6.		(In yrs. last birt	thday) If Und Month		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day,)	(ear) 9.	Birthplace (State or Foreign Country)
Director		157-28-3506	1XXXM 2□F	67	Yrs.			(Month, Day,) Aug. 1,1	938	New Jersey
and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
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r 28a	rec	10e. Street and Number			10f. 2	Zip Code		100	g. Citizen of Wha	t Country?
death with the Maryland ime 23a or 28a-f ehow Irmest be motified at	Funeral Director	7671 Fairbanks	Court			21076			1	USA
- dea	iner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec	cedent of Hispanic (pecify Cuban, Mexic	Origin? (Spec	cify Yes or No- Rican, etc.)		American Indian, White, etc.
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	tyTeyes 2 □ N If Yes, Give Year or Dates:	0 1060_91		2∑No Specia			Specify:	Black
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Viano buld be fill Mental Hi arked oth attic even	2	Everette Taylor	, Sr.			Ge	eneviev	ze Simmo	ns	
2 short and in many in		19a. Informant's Name/Relationship				ess (Street and Num				te, Zip Code)
F, F 1 and 1		Kelly Taylor (D 20a. Method of Disposition	augnter)			ace Ct.,			94547 oc. Location - Cit	v or Town State
ages ort of t: if it		1 ☑Burial 2 ☐Cremation 3 4 ☐Donation 5 ☐ Other (Spec		1	Disposition (A y, crematory o		5/17			
DESILITIOTE, INICITY INITY ALL 12-10-30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examination in white an indifficity and once.		21. Signature of Funeral Service-Ligo		Maryı	and Vet				rownsvi	iie, MD
Depariment important		13- 2. G	~			and Address of Fac desty Fur Annapoli				21054
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do r				7.7		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Aveto	rinse	Leve	tic 1	HeA	rt I	150 KS	Onset and Death
/Medical Examiner		resulting in death)	Du to (or as a	consequence	of):					
- LAAIIIIIICI		Sequentially list conditions, if any, leading to immediate	b. DIA!	beter a consequence	5					
ted nsit	nlne	Cause (Disease or injury	Due to (or as a	consequence (J., .					
ou, be executed iclan and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence (of):					1
	cal		d							
Geath certificate e attending physical for use as the left.	clan/Medi	IF FEMALE:	20							
DOX sath cer attendir	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth	2 Fetal death					23d. Date of	delivery Day Year
the ag	hysici	1 Yes 2 No	4☐ Pregnant at 1 9☐ Unknown	time of death	5 Other	(specify)			INC. INC.	ouy rou
that the detail	<u>a</u>	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlying	g cause given in Par	rt I.	23e. Did toba	cco use contribu	te to the cause of death?
ecords, law requires t as been signe	d by							1 ☐ Yes	2 No 3	Probably 4 Mnknown
law req as beer	ompleted							24a. Was an	24b. Wer	e autopsy findings available
	E				····			autopsy performe	d? deat	r to completion of cause of h? Yes 2□ No
VICAL IN ician: The certificate h rector, page	BeC	25. Was case referred to medical examiner?				26. Pla	ace of Death	(Check only one)		
On Or VICAL ding Physician: th. After this certifice funeral director, p	2	1 res 2 □ No	Hospital: 1 Inpatier	nt 2□ER/Ou	tpatient 3		Nursing Hom	e 5 Residen	ce 6 Other (Specify)
ing P	ü	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. T	ime of njury	28c. Injury at Work?		8d. Describe how	injury occurred	
DIVISION I or Attending after death. Director: After Jin by the fune	cat	2 Accident investigate 3 Suicide 6 Could not	be Goo Bloom of Injur	ry - At home fa	M rm street fact	1 Yes 2		8f Location (Stre	et and Number o	r Rural Route Number,
after after Dire	Certification:	4 ☐ Homicide determine	building, etc	. (Specify)	ini, street, ract	ory, ornoe		City or Town,	State)	ristar ricolo ricinos,
ospita hours uneral y filled	aic	29a. Certifier 1☐ Certifying F	Physician: To the best of	f my knowledge	, death occurre	ed at the time, date	and place, a	nd due to the cau	se(s) and manne	or as stated.
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	(Check only 2 Medical Exe	eminer: On the basis of and manner sta	ted.	d/or investigati	on, in my opinion, d	death occurre	d at the time, date	e and place, and	due to the cause(s)
with To	Σ	29b. Signature and title of certifier	10	repu	44 1	29c. License numbe	or of ch	290	I. Date signed (N	fonth, Dey, Year)
		Milla	Left.	m		0000	1		5/12	/
		30. Name and address of person who	Tones	s, mp	Type, Print)	DOGC Medical Science of the Company	Prich	1 21	035	
St	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	1	100				
Regist		BAY 16	ZUUO	U D.	A CONTRACTOR					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Norman Dwight Terry. Jr. 0750 AM 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 216-30-4732 Nov. 3, 1934 Washington, D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 14252 Shelby Circle 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 TNo 1f Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 'naturai', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Safeway Grocery Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if Itam 27 is marked other th any injury or other traumeth 12 Store Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Dwight Terry, Sr. ဥ Alma Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14252 Shelby Circle, Hagerstown, Maryland 21740 Nellie R. Terry - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Domaion 5 Mother (Specify) Entombment Gate of Heaven Mausoleum 5/17/06 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home Herest 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARRESI CARDIO PUL MONARY HRS /Medical **Examiner** OBSTRUCTIVE DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit FIBROSIS PULMONARY and Due to (or as a consequence of) Box 68760. ettending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Winknown Completed HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform this certificate ATHRO SCLEROSIS 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ■ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ funeral To the Hospital or Attending Pl within 24 hours after death. To the Funers! Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and the 29d. Date signed (Month, Day, Year) D 44996 May 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOONSBORD APPANS RD MD 4713 20311 ZAFAR MALIK MD 31. Date filed (Month, Day, Year) 32. Register's Signature State MAY 1 6 2006 > Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 25, 2006 2:35P MAY MILDRED AGNES ULLMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LA PLATA CHARLES CHARLES COUNTY NURSING & REHAB 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F Months Davs Hours 78 AUG.13,1927 MARYLAND Director 220-26-267] Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County ral, or Itams 23a or 28a-f show Examiner roust be notified at 1 ☐ Yes 2XQXVo Director MARYLAND ST. MARY'S HOLLYWOOD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20636 U.S.A. 25170 PINTO DRIVE within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ĀĀNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ XXWidowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. .11 HOMEMAKER EMOH NWO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event once. NATALIE WELCH WILLIAM MCKINLEY WENK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25170 PINTO DR., HOLLYWOOD, MD 20636 DEBORAH ANN GORDAN-DAUGHTES 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.JOSEPH'S CH. CEM. 5-31-06 POMFRET, MARYLAND M00479 21. Signature of Juneral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Breas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mellit 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 28 No 1 Yes : After this certifica funeral director, p 25. Was case referred to medicat examiner?
1 □ Yes 2 No 26. Place of Death (Check only one) Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending after death.

I Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide completely filled in by determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur, and Itle of certifier 0.55455 30. Named and dress of person who completed cause of death (Item 23a) (Type, Print) 5425 Allertown Rd, Suite 101, Camp Springs, Mis 20146 Fortima Hussein, M.S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 2006 Registrar

		-	State of Maryland / Dep	artment of Health and M		ene2006	17340
20	2		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic	al -	Sharon Louise Valley		May	15, 2006	8:30 a ^M
8	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
#/.i.	- ·		11140 Powder Horn Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Potomac If Under 1 Year	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		366-44-9100 1□M 2⊠F 64 Yrs.	Months Days Hours Min.	Oct. 18	,1941 Mic	higan
	P .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	and in a			10d. Inside City Limits
	ehov	5		SCALIOTI			1 ⊠Yes 2 □ No
	the M	ect	Maryland Montgomery Potomac 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
	3a or		11140 Powder Horn Drive	20854		United Sta	ates
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
92	hours after death with the Maryland ture!', or ttems 23a or 28a-f ehow al Ezaminer must be notified at	y Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No ☐ If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	,	Specify: Whit	
Ş	ture!	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation	1	6b. Kind of Business/I	
Ω	in 72 n "na nalic	plete	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ing		
212	d with giene or the	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pha	rmacologist	Į	JS Federal	Government
Maryland 21215-003	al Hy d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>ya</u>	Ment Ment Marke Marke	2	Merlin Joseph Valley		Mary Wal		:- C- d-1
Mar	12 sh th and 7 is m traum			ing Address (Street and Number or Rura) Powder Horn Drive			
<u>ရ</u>	Heali Heali tem 2		, , , , , , , , , , , , , , , , , , , ,			Oc. Location - City or	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-1 ehow enyointy or other treumatic event, Ita Musical Examinar must be notified at once.			2. Name and Address of Facility imple Tribute Fune:			
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4			23a. Part1. Eyer the disease, or complications that caused the death. Do not en shock, deheart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
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o c	ng Ph ter thi	T :uc	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe ho	w injury occurred	
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Division	or Ati siter d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town,	reet and Number or Ru , State)	ral Houte Number,
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	n 24 h	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director; A completely filled in by the fu	×	29b. Signature and title of certifier M. M. M. M.	29c. License number	29	od. Date signed (Month	Day, Year)
	22		* fatured louske May, MR	0 101716		11194 15	2006
			as Name and address of person who completed cause of death frem 23a) (Type Patr) CIA TOMS KO NAY, 1119 KO	ckville Pike,	6-100,1	Rockville	e, MD 20852
42.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NAY 1 7 2006 32 Abg/strar's Signature	geolis	,		/

State of Maryland / Department of Health and Mental Hygier [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22, **Physician** WALKER May 2006 BEULAH BOYD 11:40PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2100 Durham Road Fallston Harford Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12/18/ 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗰 F Virginia Director 216-28-7231 90 YES Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Monkton Director MD. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3444 Jarrettsville Pike 21111 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 8 0 Care iver Health or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 Is marked oth any lighty or other traumatic event 2008. Jefferson Charles Boyd Martha Ida Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara W. Trust/Daughter 2100 Durham Rd. Fallston, Md. 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State James Cemetery 5/25/2006 Monkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Sendce Licensee E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) inset and Del **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ele has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Daughter 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Home 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending death, 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State State Amend #23a Per Phy G857 7/17 Pertificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Maryth 25, **Physician** Mary Arbutus Wood 2006 $12:15 \text{ AM}_{M}$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Sunrise Assisted Living of Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 93 **1**912 214-32-2780 Virginia Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r then "natural", or iteme 23a or 28a-f sho the Madical Examiner must be notified at Ijamsville Frederick Maryland 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? U.S.A. 10e, Street and Number 3614-A Price Distillery Road death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othery injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Annie Rebecca Claig Gustavus Franklin Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7308 Parkview Drive, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Mrs. Virginia Greene, daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Resthaven Memorial Gardens May 28, 2006 Frederick, Maryland 1XX urial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Tasford PA Funeral Home Kichand MOO255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between On Control Congestive Heart Failure Immediate Cause (Final disease or condition resulting in death) Physician CUMPY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.Ó. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 Probably 4 Unknown anter Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1□ Yes 1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Living ို 1 Yes 2 No this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hoepitel within 24 hours a To the Funerel C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 25, 2006 Hron me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thoma 31. Date filed (Month, Day, Year) hunson 2. Registrar's Signature State 1 2006 Registrar JUN 0

		_ State	of Maryland / D	epartment of H	eaith and w	ientai Hydi	ene	
		For State Registrar	•	Certificate of L			g. No. 2006	17343
		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
Physi /Med		BESSIE LEE WELCH				May 27,		6:25pm M
Exam	iner	4a. Facility Name (If not institution, give street and Civista Medical Center		4b. City, Town, or LaPlat	Location of Death		4c. County of Dea	
Funav		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
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pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Aaryla Fehov	٥							1 ☐ Yes 2 X [X]o
the N	Director	MARYLAND CHARLES 10e. Street and Number	VV	ALDORF 10f. Zip Code		10	g. Citizen of What C	country?
h with	al Di	2671 MIRKWOOD COURT	r	2060)1		U.S.A	•
eme 3	Funeral	11. Marital Status 12. Was D Armed	ecedent Ever in U.S. Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
s afte	by F.	If Yes,	s ≱∏ No Give r Dates:	1 □ Yes 2 🗓 💑	Specify:		Specify:	WHITE
III K.1.Z.1.2.U333. be filed within 72 hours after death with the Maryland Hygiene. do other then "natural", or items 23s or 28s-1 show event, the Medical Exercitiva Invast be notified at	ed b	15. Decedent's Education	16a.	Decedent's Usual Occupa	ation	1	6b. Kind of Business	
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Md 2 s and 2 s		MARGARET JEAN MAZZE					-	
of Hear		20a. Method of Disposition	cemeten	Disposition (Name of y, crematory or other place		Date 2	0c. Location - City o	r Town, State
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			635 George St		T= 2 - 4			_	ersto				Washi			
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs	s. last birthday) Yrs.	If Under	Days	If Under Hours	Min.	8. Date of (Month, Dec.	Day Y	1940	9. Birthi Coul Ma	place (State ntry) ryland	or Foreign -1
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	land ow		10a. State 10b. County		10c. C	City, Town or Lo	ocation								10d. Inside C	City Limits
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	n 72 hours after death with the Marylan "natural", or items 23a or 28a-f ahow ledical Exarchi ar must be notified at	Funeral Directo	11. Marital Status	12. Was De Armed F	cedent Ever in forces?	U.S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or Rican, etc.)	No-		- Ameri	can Indian, etc.	
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Division	2555	Certification;	4 Homicide determ	nined 200. Flat	ding, etc. (Spec	cify)	геец, гасцогу,	, onice			City or	Town, S	State)	Or Hurz	ar modile redr.	nber,
_	Hospital 94 hours a Funaral C		29a, Certifier 1 Certifyin	ng Physician: To the	ne best of my ki	nowledge, deat	h occurred a	at the tim	ne date an	d place	and due to t	he caus	se(s) and man	ner as s	tated	
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medical one)	Examiner: On the	basis of exami	nation and/or in	vestigation,	in my or	oinion, dea	th occurr	ed at the tin	ne, date	and place, an	nd due to	o the cause(s)
	To tha I within 2 To the I complet	Me	29b. Signature and title of certifie	or .		∩ 1	29c.	. License	number			29d	. Date signed	(Month,	Dey, Year)	
	,- ,- 0		1 Dale TK	VMD C.	vering H	Yay China			1	43	59		MAIN	- 9	2 2	ML
			30. Name and address of person	who completed ca	use of death (It	em 23a) (Type,	Print)		/	sond,	//		1 iny	1	04	10
13	H-2		RUBERT BRUL	1459	1 Poro	MAC -	57.	H	AGE	RS7	OWN	M	0 21	174	2	
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	Regist	rar	MAY 2	3 2006 🔏	Mallin	D. A	whi									

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>		of Health of Death			iene eg. Né () (06	17345
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dear Month	th Day	Year	3. Time of Death
	Physici /Medio		Mabel B	Whitby					May 11			10:00 A M
1	Examin		4a. Facility Name (If not institution, give)	4b. City, To	wn, or Location	of Death		4c. County	of Death	
		* ₁	3666 Muddy Creel				water				e Arı	ındel
	Funeral Director	323	102-20-3770	1 M ONT C	ge (In yrs. last birthday 90 Yrs.	Months C	Year If Unde Days Hours	Min.	8. Date of Birth (Month, Day 8-7-19	Year) 15	Cou	place (State or Foreign intry) ginia
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	daryis f sho	ō		ndol	Ed	gewater						1 ☐ Yes 2 X X o
	the 28a-	Director	Maryland Anne Art	uider	Edd	10f. Zip Co			1	0g. Citizen of V	What Cou	intry?
	with Sa or		3666 Muddy Creek	Rd.		210	37			USA		
	ns 2%	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13			rigin? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - Amer	ican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or itams 23a or 28a-f show important: If item 27 is marked other then "natural", or itams 23a or 28a-f show hiptry or other traumatic event, the Medical Examiner must be notified at DDC8.	by Funeral	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 2 If Yes, Give Year or Dates:	No	If Yes, specify 1 ☐ Yes 2 ☑			Rican, etc.)		ck, White r : $B1$	_
ð	2 hou	Completed	15. Decedent's Ed	cation	16a. Dec	edent's Usual C	Occupation			16b. Kind of Bu	usiness/lr	ndustry
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Maryland	should be fund Mental I	To	James	Farthing					Myrtle	Gary		
an	2 sho and I is me		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ing Address (S	Street and Numi	ber or Rura	il Route Number	, City or Town,	State, Zi	p Code)
	l and 2 lealth im 27 i		Linda Whitby/ Dau	ighter					dgewate			
ore	of Herr		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name ematory or othe	of er place)		ate	20c. Location -	City or T	own, State
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Baltimore,	permit. Depertr Imports any inj.		21. Signature of Funeral Service Licens			22. Name and 7	Address of Faci	ity Geo Islar	orge P. nd Rd. E	Kalas I Ugewate	Tuner	cal Home 4D 21037
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	d the death. Do not e							Approximate Interval Between
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Вох	th ce tendii	an/l	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		□Ectopic preg	nancy				te of deliv	.,
	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown	at time of death 5	Other (spec	ıfy)			MO	riui	Day Year
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Ē	ng fter	o ;;	27. Manner of Death 1 D Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Time ay Year) Injury		. Injury at Work?		28d. Describe ho	ow injury occur	red	
sio	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2					
Division	l or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined	28e. Place of Ir building, e	njury - At home, farm, s atc. <i>(Specify)</i>	treet, factory, o	office	1	28f. Location (SI City or Town	reet and Numb n, State)	er or Hur	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ce	29a. Certifier 1 Certifying Phy	rsician: To the hes	t of my knowledge, dea	th occurred at	the time date a	and place	and due to the c	auce(c) and ma	nner as	stated
	24 h	Medical	(Check only 2 Medical Examone)	iner: On the basis and manner s	of examination and/or i	nvestigation, in	my opinion, de	ath occurr	ed at the time, d	ate and place,	and due i	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. /	20	29c. L	icense number		2	9d. Date signe	d (Month,	Day, Year)
	. >- 0		1 Henry	m. +47	ex		D412	16		MAL	11	2006
			30. Name and address of person who d	ompleted cause of	death (Item 23a) (Type	, Print)	~	. (0	1 4		1
			DENNIS 1	1. Ha	IMD	8	,80	Best	gate R	d.	An	napossila
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-	Regist	rar	MAY 1 6 20	106	w & A	all.						
DH	IMH 17 Rev 1/2	2001				2002.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Weihrer 10 20 PM Mas 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battmore
If Under 1 Year | If Under 24 Hrs. Maryland Medical Center

6. Sex 7. Age (In yrs. last birth University 101 5. Social Security Numbel 8. Date of Birth (Month, Day, Year) Nov. 1, 1927 Pennsylvania 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 189-20-9945 78 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "naturel", or Iteme 23a or 28a-f ehow vent, the Madical Examinar must be notified at 1 Yes 2 No Director Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14532 Roddy Road 21788 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: WWII Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Musician Music 7 Is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mabel Cramer Arthur H. Weihrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14532 Roddy Road, Thurmont, Maryland 21788 Anna L. Weihrer / Wife f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to = 10 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury o Resthaven Mem. Garden's 5/17/06 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Linnsee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DNEUMONIA Due to (or as a consequence of) /Medical retabulum + olecranon Examiner rac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Month Spendy D by Month Common Spends Spends Spends Spendy Spends attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a f be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 2 No 3 Probably 4 Unknown 1 Yes certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No 106 death. investigation untmoun 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At hom building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route 4 - Homicide ity or Town, State) 5 Residence racella

Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the

🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 19b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 64246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Baltimore 31. Date filed (Moi

State Registrar

		4	1 _ State	State of Maryland /	Department of I		lental Hygien	6000	17347
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		Wilhelming			Auer		ay Year	01902 PM
The same of the sa	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b City, Town, o	r Location of Death	Tay -4	c. County of Deat	h
	LXAIIIII	GI.	The Johns Hou	Wins Haso	Jal Balt	mine	City		
Ξ	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b	inthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
	Director		218-09-5090 10	M 2 37	Yrs.	110013	3/24/19	19 m	ARYLAND
	P .		Usuel Residence of Decedent 10a. State 10b. County	10c City To	wn or Location		•		10d. Inside City Limits
	anyla ehov	_		·					1 Tes 2 No
	Me M	Director	MD BALTIMO 10e. Street and Number	RE NA	LTIMORE 10f. Zip Code		10g (Citizen of What Co	unto/2
	with t			1	21	246	1.59.	USA	and,
	eath	Funeral	4619 MANNA	2. Was Decedent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Ame	ncan Indian,
	iter d	E.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cub	oan, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
936	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify:	HITE
2-0036	tied within 72 hours after death with the Maryland Hygiene. Ither than 'natural', or iteme 23s or 28s-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occu (Give kind of work done	pation	ina 16b.	Kind of Business/	Industry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)		1.	
7	filed wi Hygien other th	S	ω		SEAMSTRE			CLOTH	INF
ם	be fill d oth	Be	17. Father's Name (First, Middle, Last)	.0		1	e (First, Middle, Maid		
<u> </u>	should ind Men marke umatic	٦	HERBERT W		b. Mailing Address (Street	LOTT		USCH	Zie Cada) 3 +
Maryland 2121	C1 00 00	4	19a. Informant's Name/Relationship (Typ	and the state of t	1) .	. 1 1	92000 A		RSH, MD
	1 and Health am 27 ther tr		HERBERT KOBINS 20a. Method of Disposition	20h Place	560 CUIAS of Disposition (Name of		31.0	Location - City or	
altimore,	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State Greenet	ery, crematory or other place	ice) Mac	Y 31, R	ALTIMO	e ma
를	permit. Pag Department Important: any injury c	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Fu ral Service License		22. Name and Adm		CG. DE	100 1-1AA	ECCO RD
Ba	permit. Departr Importa any inje		12/10/	2161		INERAL (4		E. MD 21254
н			23a. Part1. Enter the disease, or complic	cations that caused the death. Do				74,000	Approximate Interval Between
	Dhysisian		shock, or heart failure. List only on Immediate Cause (Final	1 1	T Compation				Onset and Death
- Common	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	Infarctio	YI			Zaays
	Examiner		Les contracts and the second						
		Je	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):				
8	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events						
ő,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consequenc	e of):				
8760,	icate be executed physicien and s the burial-transit	dicai							
9 x	leath certific attending p	/Me	IF FEMALE:	3c. ff yes, outcome of pregnancy				23d. Date of del	ivon
Box	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetaf dea 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		Month Month	Day Year
P. O.	the d	Physician/Med	1 ☐ Yes 2 WNo 9 ☐ Unknown	9□ Unknown					
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Y P	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause g	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	n sign	D D	Interstitial 1	Lung Disease			1 🗆 Yes	2 No 3 P	robably 4 Unknown
00	s bee	olete	Coronary Arter	v Disease			24a. Was an	24b. Were at	utopsy findings available completion of cause of
Vital Records,	The la te ha	Completed by	-coronal g	7 3.3230			autopsy performed; 1 Yes 2 X	? death?	- 1
<u>ta</u>	rtifica	Be C	25. Was case referred to medical			26. Place of Deat	h (Check only one)		
>	Physician: this certific ral director,	To	examiner? 1 Tes 2 No	lospitaf: 1 xInpatient 2 ☐ ER/6	Outpatient 3□ DOA O	ther: 4 🗆 Nursing Ho	ome 5 Residence	6 □Other (Spe	cify)
n of	ng Pt fter tt neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	. Time of 28c. Injury Wo	ury at ork?	28d. Describe how in	fury occurred	
sio	Attending r death. ector: After by the fune	catio	2 Accident investigation			Yes 2 □No			
Division	or Att	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - At home, building, etc. (Specify)	farm, street, factory, office	•	28f. Location (Street City or Town, St		ural Route Number,
	pital ours a erai C	O	29a. Certifier Certifying Phys	sician: To the best of my knowled	Ige, death occurred at the	time, date and place	and due to the cause	v(s) and manner a	stated
	the Hospital or hin 24 hours after the Funeral Dir upletely filled in	edical		ner: On the basis of examination and manner stated.					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	/		ise number		Date signed (Mont	
	1		1 Sunan	ompleted cause of death (Item 23:	1P RE	5-000	Ma	4 29,5	1006
	n		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type, Print)		- Alleria	1	
	_		Joselyn Kim The	2 Johns Hopkin 32. Resistrar's Signature	5 Hospital	600 N. Woi	test, Balt	imore, Mi	aryland 21287
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Paristral s Signature	(break)				

			For State Registrar	State of M	arylar		artment o			Mental Hy	giene 2	008	17:	348
	Physicia	an	1. Decedent's Name (First, Middle, Last EMANUEL BLOW	1)						2. Date of De	Day	Year	3. Time of D	
	/Medic Examin		EMANUEL BLOW 4a. Fecility Name (If not institution, give	street and number)			4b. City, To	wn, or l	Location of Death	MAY	~- ~	by of Death	2:20	4
BLOW		Ü	SINA HOSPIT	AL OF A	3ALT	more	BAL	TIM	DRE CI	ГУ		NA		1
1	Funeral Director		5. Social Security Number 6. Se 831. 36. 5949 Usual Residence of Decedent		ge (In yrs. 16	last birthday) Yrs.	If Under 1 \ Months D	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02 · 13	y, Year)	9. Birth	place (State or intry) NC	Foreign
CMANUE	Maryland -febow fled at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City	
Ž	the Maryla 28a-f eho	ctor	MD NA		BAL	MORE							1 🗗 Yes 🤄	2 ∐ No ————
MA	5 0 8	Funerai Director	3326 DOLFIELD AV	ENUE			10f. Zip Co	215		į	10g. Citizen of	What Col	intry?	
D	death v	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	J.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No			ican Indian,	
Maryland 21215-0036	hours after turel', or its al Exemine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Mayes 2 ☐ If Yes, Give Year or Dates:			1 □ Yes 2 2		Specify:		Spec			
75-6	"na	iete	15. Decedent's Edi (Specify only highest grad	ucation de <i>completed)</i>		16a. Deced	dent's Usual C kind of work of DO NOT use i	Occupatione di retired)	tion uring most of work	king	16b. Kind of I	3usiness/I	ndustry	
W 212	illed within Il Hygiene. other than ".	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		CIPLE				BALTIMO	IRE	CITY	
4N0WN land 21215	be filed withing that Hygiene. Id other than event, the M	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nam			me)		
N P	2 should be and Mental is marked o	2	LOUIS BWW 19a. Informant's Name/Relationship (7	ivna (Print)		10h Madis	a Address /S		LEONA A	NOERSON	-	State 7	in Cada)	
Z Z	s 1 and 2 should f Health and Men item 27 is marke other traumatic		BERCELLA BLOW	(WIFE)		1	•		AVENUE.		. MO 21		p Code)	
More,	of Health of Health fitem 27		20a. Method of Disposition 1 Surial 2 Cremation 3			Place of Dispo	sition (Name	of		Date	20c. Location	- City or T	own, State	
AT FN altimore,	Pages thent of tant: If it		4 □ Donation 5 □ Other (Specify)	GA	RRISON	• • •		0 - مان		OWINGS	MIU	QM 2	
Ball	permit. Pages Department of Important: If ii any injury or o		21. Signiture of Funeral Service Licen	See Total		22 VAL 51	Name and AUGHN C.	Address GR	S OF FacilitY REENE FU ATT: PIKE	NERAL S BALTO	ERVICE MD 2	1229		
	Physician /Medical		23a. Part1. Entire the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. FEVEL	ine. R 0	F UNI	LNOW	N	ORIGIA	J	rrest,		Approximate Interval Betwo Onset and De	reen
8760, cM	ate be executed by sicien and hysicien and inhe burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Ommu Due to (or as	a consec	quence of):	UIRF	0 (PNEUM	ONIA			U DAY	75,
Division of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be in death. In death. ector: Atter this certificate has been signed by the ettending physicie by the funeral director, page 2 should be detached for use as the bur	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Feta	aldeath 3□	Ectopic preg					ate of delivionth	•	ear
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions co	ontributing to death of	but not res	VE PU	nderlying cau		n in Part I. Y DISEASI	-	tobacco use con Yes 2 □ No	atribute to 3 ☐ Pro	the cause of dea	
Reco	The law re ate has bee page 2 sho	Completed								24a. Was auto perfi 1 \(\text{Yes}	an 24b psy prmed? 2 No	Were aut prior to co death? 1 \(\text{Yes}	opsy findings avompletion of cau	vailable use of
/ita	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Otho	26. Place of Dear	th (Check only	one)			
on of	ding Phys th. : After this of funeral dir	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		28b. Time of Injury		Othe Linjury Work 1 Y	4 Nursing no		how injury occu		fy)	
Divisi	ai or Attendi s after death si Director: A ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At h tc. <i>(Speci</i>	nome, farm, str	reet, factory, o	office			Street and Nun wn, State)	ber or Rui	ral Route Numb	er,
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best liner: On the basis and manner s	of examina	owledge, death ation and/or in	h occurred at vestigation, in	the time my op	e, date and place, inion, death occur	, and due to the rred at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)	
	Within Com	Σ	29b. Signature and title of certifier	LNIQ	B. S				_000		29d. Date sign	~ I		r
	2.		30. Name and address of person when) / (14				C 3			May	XU	2006)
	10			wort,	MB	B5	SINA	1 11	OSPITAL	OF	PALTII	NOR	E	
s ~	Sta Registr		31-Date filed (Month, Day, Year)	32. Regist	trar's Sign	ature	Coste	p						

DHMH 17 Rev 1/2001

		-		State of Ma		Depa	artmen		and M			006	173	49
	D 1		Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of	Death
	Physicia /Medic	al	James R. Burley				Γ			May 29,20	006	. (5 4	8:15	РМ
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)			4b. City,	Town, or Location			4c. Cou	nty of Death		
	Funeral Director		Future Care Homewood 5. Social Security Number 212-24-0342 6. Sex	M 2DE	e (In yrs. last	birthday) Yrs.	If Under Months	Baltimore 1 Year If Under Days Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day,) 07–04–1936	(ear)	9. Birthp Coun Mary 1	ace (State o try) and	r Foreign
	pu >	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Lo	cation					11	Od. Inside Ci	tv Limits
	faryla show	ō			roo. Ony, re								1X Yes	
	28a-	Director	MD NA 10e. Street and Number			Balt	imore 10f. Zip	Code		100	g. Citizen o	of What Coun	try?	
	h with	alD	1836 W. Fairmount Avenu	ie				212	23			USA		
	ems a	iner	11. Marital Status	2. Was Decedent Armed Forces?		13.	Was Deced	ent of Hispanic O	rigin? (Spe in, Puerto l	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	s afte	by Funeral	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No		1 ☐ Yes	2to Specify	<i>'</i> :		Spe			
8	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Ite Madrell Examiner must be notified at		15. Decedent's Educ	ation	10			Occupation		16	6b. Kind of	Black Business/Inc	<u> </u>	
Maryland 21215-0036	thin 7: e. an "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	rk done during mo se retired)	St of Workii	ng				
21	led wi lygien her th	Cou	10					Laborer	or's Namo	(First, Middle, Ma	idon Sum	Retail		
and	l be fil ntal H ad ott	Be	17. Father's Name (First, Middle, Last) William H. Burley					16. MOL				iame)		
Ž	should nd Me mark matic	Jo	19a. Informant's Name/Relationship (Typ	e, Print)	1	9b. Mailii	ng Address	(Street and Numl		iola Burley I Route Number, (wn, State, Zip	Code)	
Z	alth ar 27 Is		Annabelle Duckett/	Sister		183	6 W. F.	airmount A	venue 1	Baltimore,	MD 21	223		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Examiner must be notified at any injury or other traumatic event, the Marical Examiner must be notified at ange.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	amoval from State	20b. Place ceme	of Dispo	osition (Nam matory or o	ne of ther place)	D	ate 20	oc. Locatio	on - City or To	wn, State	
Ë	Pag ment lant: I	1	' 4 ☐ Donation 5 ☐ Other (Specify)		Mt. Z	Annual Control of the Person Street	emeter		06-03-2	2006 1	mslow	one, MD		
3ali	permit Depart Import any in		21. Signature of Funeral Service License	• •				d Address of Faci	-	37 G13				
	402 4 6		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that cause	d the death. D					N. Gilmor		t Balto,	Approximat	ө
	Physician		Immediate Cause (Final	e cause on each li	ine.			echne					Onset and I	
	/Medical	resulting in death) Due to (or as a consequence of):												
Ľ	Examiner		Sequentially list conditions, b.		Dema	who	2							-
	ed sit	ulne	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequent	oa oty:								
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a conse uen	ce of):								
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68	death certificate e attending phys id for use as the	Physician/Medi	IF FEMALE:		- 7							, ,		
Вох	ath ce attendi	lan/i	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal de	ath 3[⊒Ectopic pr ⊒ Other (sp					Date of delive Month		Year
P.0.	0 0 0	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or death	1 30	_ Other (sp	ecity)						
_	s that the ned by th e detache	by Pr	Part II. Other significant conditions conf	tributing to death t	out not resultin	g in the u	ınderlying c	ause given in Part	l.	23e. Did toba	cco use c	ontribute to th	e cause of c	feath?
ords	law requires that as been signed b 2 should be det	ted t	Comsect			•		-		1 🗆 Yes	2 🗆 No	3 ☐ Prob	abiy 4 🚉	nknown
of Vital Records,	a 0, 0	Completed	mxichy	1 De	mes	2102	7			24a. Was an autopsy			osy findings npletion of c	available ause of
<u>E</u>	Th ate pag	Con								performe 1 Yes 2	2 No	death? 1 \(\sum \) Yes	2 No	
V Its	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpati	ant 2000	/Outpatie	nt 3□ DC			n <i>(Check only one)</i> me 5 ☐ Residen		Other (Coorie		
	a Physer this eral di	-	27. Manner of Death	28a. Date of Injui		b. Time o	_	8c. Injury at Work?		28d. Describe how			"	
ion	Attanding or death. actor: After by the fune	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, De	ly real/	Injury	М	1 Yes 2	No					
Division	To the Hospital or Attanding Physic within 24 hours after death. To the Funaral Diractor: After this completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, farm, st	reet, factory	, office	1	28f. Location (Stre City or Town,		ımber or Rura	l Route Num	ber,
	spital lours a naral i		29a. Certifier 1 Certifying Phys											
	ne Ho n 24 h he Fui pletely	ledical	(Check only 2 Medical Exemin	er: On the basis of and manner st	of examination tated.	and/or in	rvestigation	, in my opinion, de	ath occurr	ed at the time, dat	e and plac	ce, and due to	the cause(s	;)
	vithi To tl	Σ	29b. Signature and title of certifier	1		MD	290	: License number		290	_	ned (Month,		
			P	NN -			-	D 3146	4		31	30/0	, 0	
	3		0 / 0 1112	MI, 8.	21 N	, El	Print)	ST SU	vite -	30F 13A	tim	TOKE	MI)	21201
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 2 2006	32. Regist	rar's Signature	Coest	ال ال							

Please Type or Print in Black Indelible Ink Charles P. Brown State of Maryland / Department of Health and Mental Hygiene 2006 17350 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 27, 2006 Medical Examiner 0337 hrs BROWN JR CHARLES Ρ. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore N/A 5 Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Director Months Days Hours Min. Foreiar 1X M 2 Country) 215-75-1478 Yrs 03/27/2006 MARYLAND Usual Residence of Decedent any 10a State 10b County I0c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No Director MARYLAND BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1519 MADISON AVENUE **APT 201** 21217 U.S.A. 23а Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. Yes 2 X No Widowed Divorced If Yes. Give Year Yes 2 X No specify Specify BLACK ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. N/A N/AN/A17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be SHAUNTA ALSTON CHARLES P BROWN SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 injury or other trauma 1519 Madison Ave., apt 201, Balto., Md. 21217 Shaunta Alston/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State KING MEMORIAL PARK 06-06-06 BALTIMORE, MARYLAND Denation 5 Other Specify Si vature of Vineral Service-Lio va 22. Name and Address of Eaching WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part I. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cay se on each line Between Onset and /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and tran. Physician/Medical X UNPENDED AMENDED item#1,23a,27,28a-f,perME,g858,8/28/06 TT Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: phy the b 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? certificate ✓ Yes 2 ✓ Yes 2 No 25 Was case referred to medical 26 Place of Death (Check only one) examiner? Other 4 DOA Nursing Home 5 Residence 6 After this 1 🗸 Yes 2 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural 5 Pending Director: d in by the f 1 Yes 2 No Fnd 7/27/2006 Fnd 3:00 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1519 Madison Ave Apt 201 Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be determined Suicide (Specify) found at home Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. cal To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 28, 2006

en

30 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)



ORIGINAL

			1 - For State Registrar	State of Mary		artment rtificate				giene 2 ()	06	17351
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Earl Junius Bagle						2. Date of De Month 05		Year 06	3. Time of Death
The second	Examir		4a. Facility Name (If not institution, give s 2018 Harlequin Te	errace		Si	lver	Sprin	g	4c. County	gome	ery
ļ	Funeral Director		5. Social Security Number 6. Sex 217-02-3842 Usual Residence of Decedent	XM 2□F 34	yrs. last birthday) Yrs.	If Under 1 Months		Under 24 H lours Mi		iv. Year) -1971	9. Birthp Coup Was	place (State or Foreign play) nington DC
	he Marylan 28a-f ehow otified at	ector	MD 10b. County MD Montgor		silver	Spring						10d. Inside City Limits 1 ☐ Yes 2/□ No
	e 23a or 2 nust be n	Funeral Director	10e. Street and Number 2018 Harlequin Te			10f. Zip C		20904		10g. Citizen of W USA		
9000	be tiled within 72 hours after deeth with the Maryland ntal Hyglene. dother then "neture!, or iteme 23a or 28a-f ehow event, the Medical Examinat must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2(∑No If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 ☐ Yes 2 ☐		nic Origin? lexican, Pui pecify:	(Specify Yes or No erto Rican, etc.)	Specify:	, White,	
Baltimore, Maryland 21215-0036	d within 72 h giene. or then "net the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual (kind of work : DO NOT use ntaina:	done durin retired)	n ig most of w	rorking	Marylar Highway	nd St	•
yland	should be filed and Mental Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Warl J. Bagley St	·			18.	Mother's N Moez	ame <i>(First, Middle,</i> e11e	Maiden Sumame	9)	
e, Mar	lend 2 leelth a m 27 li		19a. Informant's Name/Relationship (Ty, Kimberly Bennette	e/wife	201	8 Harl	equin		Rural Route Number Silver S	Spring MI	209	904
Itimor	t. Page: rtment o rtant: if njury or		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Chesape	ake Cre	er place) emato		Date 06-02-20		svil	Lle, MD
Ba	Depe Impo eny is		21. Signature of Funeral Services License	aum		933 G:	ist A	ve Si	Cremation lver Spri	ng MD 20		
1	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ne Defic				ac or respiratory as	iest,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Pneumocy Due to (or as a co	stis Pne	umonia						Months
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P.O. Box 6	the death certifi y the ettending iched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic preg Other (speci		_		23d. Date Mon		ory Day Year
	The law requires thet the de ste hes been signed by the e page 2 should be detached f	ed by P	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying caus	se given in	Part I.	100			ne cause of death?
al Reco		Completed								rmed? de	ath?	psy findings available inpletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours star death. To the Funeral Director: After this certific completely filled in by the funeral director,	tion: To Be	25. Was case referred to medical examiner? 1 Yes 27 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 3 28a. Date of Injury (Month, Day Year) Representation of Injury M			04	Nursing	eath Check only o Home 5 X Resid			r)
Divisi	tal or Atter 's efter dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, o			28f. Location (S City or Ton	Street and Number n, State)	or Rura	l Route Number,
	To the Hospital within 24 hours e To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of m er: On the basis of exa and manner stated.	y knowledge, death imination and/or in	occurred at 1 restigation, in	he time, d my opinio	ate and place n, death occ	ce, and due to the courred at the time,	cause(s) and man date and place, ar	ner as st nd due to	ated. the cause(s)
	To the within 2 To the complex	×		'AMA			cense nur			29d. Date signed $5-3$		
	5	_	30 me and address of person who co	mpleted cause of death	(Item 23a) (Type, OX 838	Print)	9 ac	i15.	ersbn	rg m	0)	10883
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 2006	3 Registrar's	Signature /	N.						

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Talbert Melvin 1750P M 2006 27 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2728 Chickentown Road Freeland Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 22, 1919 5. Social Security Number 214-03-0256 6. Sex. 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 86 Maryland Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore County 1 Yes XXNo Freeland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2728 Chickentown Road 21053 United States "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer State Highway N/Ă 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Susie Francis Talbert John Henry Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susie Markline 149 Bon Street New Freedom Pennsylvania, 7349 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any injury or otl wiseburg U.M.Chur.Cem. May 31,2006 Hereford Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee reaceful Alternatives Funeral&Cremation Ctr.P.A. 2325 York Road, Timonium Maryland 21093 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. "List only one cause on each line." Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) and ovascular Physician Hrterio Schonotic 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed this certificate 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 1 🗌 Inpatient ဥ 1 Yes 2 □ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pendina М 1 ☐Yes 2 ☐No investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 018667 Tolo las le Piu 0. Name and address of person who completed cause of death (Item 23a) ype, Print) CT. Lutherville, Maryland 21093 tello, MD Trimble Hill 31. Date filed (Month, R 32 pgistrar's Signature State 2006 Registrar

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State of Maryland / Department of Health and Mental Hygiene

John Timothy Bra		S 1- For State	tate of Maryla				Menta	l Hygiene		
	1	Registrar		Cer	rtificate of	Death			Reg. No 2	006 1735
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AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing	Address (Street	and Numbe	r or Rural Route Nu	imber, City or Town	n, State, Zip Code)
MD and 2 shoulth and m 27 is aumati		Kathleen P.	Brady/moth							, VA 23462
re, slan free free		20a. Method of Disposition 1 Burial 2 X Cremati	on 3 Removal fro		Place of Dispos crematory or oth	ition (Name of cen ner place)		June 2,	20c. Location -	City or Town, State
Page Page nent o		4 Donation 5 Other			st Arun	del Crema		2006	Odento	n, MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other transmatic event, the Medical Examiner		21 Signature of Funeral Service			22. N	ame and Address	of Facility	1 Home &	Cremator	v. P.A.
a 50 a ii		Domenico (modeo	M014	42/ 14	ll Annapo	olis R	d. Odento	on, MD 21	113
Physician	- 1	23a. Part I. Enter the disease, failure. List only one caus		aused the death	Do not enter th	ne mode of dying,	such as card	iac or respiratory ar	rest, shock, or hea	Approximate Interval Between Onset and
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	ļ	30 Name and address of person	1 TOUR	W Total	230\				1, 230	
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Amend Items: 10a.b.c.e.f.per Inf. G-856 6/28/06.rb....

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Be	į,	17. Father's Name <i>(First, Middle, Last)</i> [homas Clifford Bi	11 i g				18. Mother's Nam Ielba Hei		.,		10)	
၉	-	19a. Informant's Name/Relationship (7)		19h Maili	na Addre	1	nd Number or Ru		,		State Zin	Codol
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and a		21. Signature of Funeral Service Licens		Chesapea	2 Name	and Address	of Facility					Maryland
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1		resulting in death)	···	consequence of):	5-0-							10 mone.
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Examiner		if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	orisaquanca of).								
хап	3	that initiated events resulting in death) Last	Due to (or as a o	consequence of);								
			J									
Physician/M		230. Yvas decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2		Tectonic	pregnancy				23d. Dat	e of delive	ry
sicia		in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tin		Other (-	Mor	nth	Day Year
Phy		9 Unknown										
Ď	î '	Part II. Other significant conditions con	ntributing to death but i	not resulting in the u	inderlying	cause given	in Part I.			-		e cause of death
eted						-			Yes	2 XNo	3 Prob	ably 4 □Unkno
e Completed								24a. W	topsy	24b. V	Were autor	osy findings availant expletion of cause
ပိ								1 Tes		No 1	☐ Yes	2□ No
B	1	25. Was case referred to medical examiner?	Hospitat:			Other	26. Place of Deal			secor		10.000
		1 192 5 TVIA0	1 ☐ Inpatient	2 ER/Outpatier		, OA	4 Nui sing no	ome 5 A Re 28d. Describ				')
<u>ار</u>		27. Manner of Death	27. Manner of Death 1 Anatural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury 28c						.0 11011 11	ijary occurr	ou	
-			(,)				_			et and Number or Rural Route Number, State)		
rtification: T			28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, facto	ory, office		28f. Location City or 7	(Street Town, St	and Numberate)	er or Rura	Route Number,
Certification: T		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Phy	28e. Place of Injury	Specify) my knowledge, deat camination and/or in	h occurre	d at the time,	, date and place, nion, death occur	City or 1	ne cause	ate)	nner as st	ated.
al Certification: T		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Natural 5 Pending investigation 6 Could not be determined	28e. Place of Injury building, etc. (sician: To the best of mer: On the basis of gy	Specify) my knowledge, deat camination and/or in	h occurre vestigatio	d at the time,	nion, death occur	City or 1	ne cause e, date a	ate)	nner as st and due to	ated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

apella bialiu		1- For State Amend #20b Per FH G856 6/07/1060 JHeath		g. No 201	06 1735
Physicia	an/	Decedent's Name (First, Middle,Last)	2 Date of Deat Month	h Day Year	3 Time of Death
Medical Exami		Isabella N. Bland 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 28, 20	4c. County of Dea	1652 hrs
		Johns Hopkins Hospital Baltimore City		io. County of Boo	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birt	h(MM/DD/YYYY) 9. E Fore	ign
Director		218-/3-5956 1 M 2 XF Yrs 7 7	Oct.17	,2005	ountry)Maryland
ģ	ŀ	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	5	Maryland Baltimore Catonsville			1 Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
ith the 23a or		12 Bloomingdale Avenue 21228 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	USA	erican Indian, 8lack,
eath w	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	and majori, order,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify:	White
5-0036 led within 72 hours af Tygiene. other than "matural the Medical Examin		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of Business	s/Industry
die in a	ompleted	0 never worked			
	ပ၂	17. Father's Name (First, Middle, Last) 18.Mother's Name			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than attre event, the Medica	o Be	Jason Tyler Bland Michele 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Lynn C		te, Zip Code)
	-	David Caughy Grandfather 12 Bloomingdale Avenu		nsville, M	D 21228
imore, MI Pages I and 2 s nent of Health a ant: If item 27		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b Place of Disposition (Name of cemetery, crematory or other place) 6/1	0/2006	20c. Location - City of	or Town, State
Baltimore, MD permit. Pages I and 2 sh Oepartment of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other Specify Crest Lawn Mem. Garden 6/3	/06		sville, MD
Baltimore permit. Pages Department of H Important: If it		21 Signature of Funeral Service Licensee 22, Name and Address of Facility, te Funeral Home of Ca	tons∀i	le, Inc.	MD 21228
Physician		23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Blunt Force Injuries			Death
		or condition resulting in death) Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause			
1	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit		d			
ਤ ਲੋਵ	Medical	UNPENDED AMENDED IF FEMALE. 23c. If yes, outcome of pregnancy		23d Date of delive	Prv
6876 ertificat ding phy	~	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	ancy	Month	Day Year
Box 68760 e death certificate be the attending physical	ysician	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. Besthat the degreed by the	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		bacco use contribute t	
S, P.C uires that n signed l	ed by				obably 4 Unknown
ords aw requi nas been	Completed		24a. Was a autop		autopsy findings available completion of cause of
tal Recian: The l	Con		1 🗸 Yes		
Vital ysician: his certi director	Be (25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 Oth	er:
1 of \ding Phy	n: To	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sion ttendideath ctor: /	atio	2 Accident Investigation			
Division of Vital Records, pital or Attending Physician: The law requiremental after death eral Director: After this certificate has been sifiled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	or Town, S		Rural Route Number, City
Hospit 14 hour Funers		4 Momicide (Specify) Single Family 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the timeral director, page 2 should be detached for use as the burit.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	at the time, date		
. > - 0	Ź	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d Date signed (M May 29, 2006	onth, Day, Year)
,		30. Name and address of person who completed cause of death (Item 23a)		.viay 25, 2000	
1		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
	tate	HIN DE OBOS LECO. EX LIGARITA			
Regis	trar	JUN 0 2 2006 Julian S. Sporte			

			1 - For State Registrar	State of M	Maryland	-	artment rtificate			and M		giene, Reg. No.	006	17356
	Physici	an	1. Decedent's Name (First, Middle, L	_							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Fred	BARNI			-				dun	01	2006	0629 AM
	Examin	ier	4a. Facility Name (If not institution, g		ər)				Location of	of Death		4c. Cou	unty of Death	_
			Howard Co. Gen. 5. Social Security Number 6.		Age (In yrs. las	t hirthday)	If Under	lumb	If Under	24 Hrs	P. Dato of Pir	th.	Howai	
п	Funeral Director		212-24-7444	1∆ M 2□F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da Jan	Year)	Mary	place (State or Foreign ntry) Land
			Usual Residence of Decedent											
	how		10a. State 10b. County	_	10c. City, 7									10d. Inside City Limits
	8a-f	cto	Maryland Carrol	T	Ha	mpste								1 □ Yes 🏋 No
	th with the 23a or 2	Funeral Director	10e. Street and Number 1933 Hanover Pi	ke			10f. Zip 210					_	of What Cou	ntry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of haatht and Mental Hygiane. Importent: if Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at ance.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 \(\bar{\text{L}} \bar{\text{Yes}} 2 \) If Yes, Give Year or Date	s? ⊐No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)		Race - Ameri Black, White, ecify:	
ò	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usua	Occupa	ition			16b. Kind o	of Business/Ir	ndustry
215	hin 7.	ple	(Specify only highest of Elementapy/Secondary (0-12)	rade completed) College (1-4)	or 5+)		kind of wor DO NOT us		luring mos)	t of worki	ng			
7	od wit	Completed	9	10		N	lachin	ist					& Deck	cer
Maryland	uld be filk fental Hy rked oth	To Be											name)	
Mary	nd 2 shou Ith and h 27 is ma													Code)
ē,	f Haa f Haa ftem other		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	e of	1					own, State
Ë	Page ient o nt: if ry or				" Mill	ers C	hurch	Cem	i. Jui	ne 5	2006	Mille	ers. Mo	
Baltimore,	permit. Departmine importe any inju		**Eburial 2 Cremation 3 Removal from State **A Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee **Manage and Address of Facility **The Burial 2 Cremation 3 Removal from State Millers Church Cem. June 5,2006 Millers, Md. **Plantage of Facility											
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	sed the death.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		cardia	0 :	favet	7.41						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	nce of):	^							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Gash Due to (or	as a conseque	nce of):	x be	oed						
V	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	es a conseque	nce of):	y							
8760	ate be e hysicier the buri			d	ion ca	ncei								
9	ing ph	Med	IF FEMALE:											
P.O. Box	The law requires that the death certificate be executed to has been signed by the attanding physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal de at time of deat	eath 3	Ectopic pre Other (spe				· ·	23d.	Date of deliv Month	ery Day Year
	res that the signed by be detact	by Ph	Part II. Other significant conditions	contributing to death	but not resulti	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did t	× .		he cause of death?
ecords,	w require been sl should l	ted									1 🗆 '	Yes 2 N	o 3 ☐ Prot	oably 4 □Unknown
ecc	law rias be	Completed									24a. Was	osy	prior to co	opsy findings available impletion of cause of
<u>~</u>		Col									1 Tes	rmed? 2 X No	death? 1 ☐ Yes	2 🗆 No
/ita	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hamital				045			(Check only o			
of Vital	× .50 O	2	1 Yes 2 No	Hospital: 1 ☐ Inpa		VOutpatien		A Journal	^{N:} 4 □ Nu		ne 5 Resi			(y)
n	ding f	lon	27. Manner of Death 1 Natural 5 □ Pending	(Month, i	Day Year)	8b. Time of Injury	M	3c. Injury Work	al ? ′es 2□I		28d. Describe I	low injury oc	curred	
Division	i or Attending efter death. Director: Afte I in by the fune	fical	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of	Injury - At home	e, farm, str					28f. Location (Street and Nu	umber or Rura	al Route Number.
Div	s efter al Direct	Certification:	4 Homicide	building,	etc. (Specify)		,			W	City or To	vn, State)		
	To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	edical (29a. Certifier 1 Certifying I (Check only one)	Physicien: To the be eminer: On the basis and manner	st of my knowle of examination stated.	edge, death n and/or in	occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and plac	manner as s ce, and due to	stated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	2 0			29c.	License	number			29d. Date sig	gned (Month,	Day, Year)
•			1 TX Tank	at mo			D	005	571	77	1948	Jun	01,	2006
	12		30. Name and address of person wh	o completed cause of	f death (Item 2	3a) (Type,	Print)	CEL	DAR	LA	1 000	um G I.	A, M.	tated. o the cause(s) Day, Year) 2006 A 1044
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 2 2	32. 3 9i	strar's Signatur	0	made a							
			001102	AUG CA	Sec 1	M	NO COL							

				Please 1 - State Registrar	State of Ma		l / Depa		Health and	•		2006	173	357
		Physici		Decedent's Name (First, Middle, La	Robert B	ialek				2. Date of D Month May	Da	у 2006 ^{Үөөг}	3. Time of 8:45	Death A M
		/Medic Examin		4a. Fecility Name (If not institution, given Hebrew Home of Great Hebrew		ineto	n		or Location of Deat	h		County of Deeth	v	
		Funeral Director		5. Social Security Number 6. S		e (in yrs. ia		If Under 1 Year Months Day	ar If Under 24 Hrs	8. Date of B (Month, D) Feb. 3	rth	9. Birthp	lace (State of try) ngton,	r Foreign
7				Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc						0d. Inside Cit	ty Limits
	40	or 28s-1 s	Directo	Maryland Montgon 10e. Street and Number			Re	10f. Zip Code)		-	tizen of What Coun	•	28,140
	10	ter death w Items 23a	by Funeral Director	6121 Montrose Ro	12. Was Decedent Armed Forces?		. 13. W	/as Decedent o Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puer	specify Yes or N to Rican, etc.)		14. Race - Americ Black, White,	an Indian,	
	21215-0036	hours at	ed by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		I 16a. Decede	☐ Yes 2ॼ N ent's Usual Occ	cupation		16b. H	Specify: Whi		
	1215	within 72 ene. than n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	5+)	(Give k life. D Owne	O NOT use reti	ne during most of wo ired)	rking	Mus	ic/Record	ls	
	Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleeling and Mental Hygiene. To fleeling 21s marked other than "natural", or items 23s or 28s-1 show with the m21s marked other than "natural", or items to retilied at or other traumatic event, in a Medical Examinar must be notified at	To Be Co	17. Father's Name (First, Middle, Last Benjamin Biale			· _ ·		18. Mother's Nat Fannie	ne (First, Middle Colodny		n Sumame)		
	Mary	ind 2 sho eith and h 27 is me er treume		19a. Informant's Name/Relationship Marvin Gerstin/Gu					et and Number or Rein Ave.#10					20815
	Baltimore,	Pages 1 a nent of He nt: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		Mon Cre	matori	ation (Name of atory or other p uin, Inc	200	Date y 31, 06	Bet	ocation - City or To hesda,Ma	ryland	
	Balti	permit. Pages 1 Department of F important: If Ite any Injury or ot		21. Signature of Fun ral Service Lice		00198	Ro 755	Name and Add bert A. 7 Wisco	ress of Facility Pumphrey nsin Ave.,	Funeral Betheso	L Hou	ne/Bethes D 20814-3	da-Che ie, Ind 501	c.
KOBS-PT	60,	/Medical Examiner and prize transit and prize tr	icai Examiner	23a. Part1. Erffer the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as Due to (or a)	a conseque	ance of):	OCAA	DIAL.	EN F	AR	CTION	Approximate Interval Betwood Onset and D	Ween
SIV	O. Box 68	The law requires that the death certificate are has been signed by the attending phy: page 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3 🗆	Ectopic pregnar Other (specify)				23d. Date of delive Month	•	'ear
0	ds, P	w requires that the base is signed by should be detact	by	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the un	derlying cause	given in Part I.		tobacco Yes 2	use contribute to th		eath? Inknown
	Division of Vital Records	The law requii ate has been s page 2 should	Completed							24a. Wa: auto perf 1 ☐ Yes		death?	osy findings anpletion of ca	
	/ita	ding Physician: The h. h. After this certificate hi funeral director, page	Bec	25. Was case referred to medical examiner?					26. Place of De	ath Check only	one)			
	of \	shyst this c	ဥ	1 Yes 2 No	Hospital:		R/Outpatient	3LI DOA				6 ☐Other (Specify)	
	sion	To the Hospitel or Attending Physician: within 24 hours after death as a feet this certified to the Funeral Director: After this certified completely filled in by the funeral director. I	Certification:	27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		y Year)	28b. Time of Injury		☐ Yes 2 ☐ No	28d. Describe		ny occurred	Paula Mumb	ha.
	Div	urs after or an or a ster or after or a		4 Homicide determined	building, et	c. (Specity)				City or To	wn, State	e)		761 ,
	2	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical		hysicien: To the best miner: On the basis o and manner st	f examination								
4	,	To t To tl	Σ	29b. Signature and title of certification	mum			29c. Lice	nse number		29d. Da	te signed (Month, E	2001	,
	_	51		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type, F	Print)	ise Re	P. Roy	le V	11/2 M	0208	 了
	3	Sta Registr	-	31. Date filed (Month, Day, Year)	3. Registr	ar's Signatu	Scarle			7 1 -00		The state of the s	, , ,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 17358 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Evelyn Beatty /Medical May 26 2006 9:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9113 Cove Point Road Edgemere Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🔀 F Director Yrs. 019-26-1281 71 April 5,1935 Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or itama 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Director Maryland Baltimore Edgemere 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heath and Mantal Hygiene. Important: if itam 27 is marked other than "sturat", or itama 23s any injury or other traumatic avant the 9113 Cove Point Road 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: White 3 ☐ Widowed 4 ➡ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis A. Gauthier Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David P. LeTourneau (son) 9113 Cove Point Road Edgemere, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/30/2006 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility once Duda-Ruck Funeral Home of Dundalk, 7922 WiseAvenue Dundalk, MD 21222 23a. Part. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician chronic obstructive pulmonary /Medical Due to (or as a consequence of): Examiner Due Io (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last artery Examine the burial-transit ischemic cardiomysposh Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physicien ician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Dale of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy igned by the atte in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death Day 5 Other (specify) Physi 9□ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should Completed 1 Yes 2 □ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of dealh? 24a. Was an certificate has autopsy performed? 1 Yes 2 No or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. М 1 TYes 2 TNo 2 Accident investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1227650

MD

29d. Date signed (Month, Day, Year)

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	Funeral		5. Social Security Number	6. Sex 7		last birthday)	If Under Months	1 Year	If Under		8. Date o	of Birth			lace (State or Foreign
	Director		219-28-3924	1□M 2対F	76	Yrs.	MOTUS	Days	Hours	MIII.	May				t Virginia
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21215-0036	"natural",		15. Deceden	t's Education		16a. Dece	dent's Usua	I Occupa	ition			10	6b. Kind of B		
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Baltimore,	Departing Departing Important In poce.		21. Signature Funeral Service	Licensee	Q								undall ryland		
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	10		30. Mane and address of person	who completed cause	of death (Iter	m 23a) (Type,	Print)	2/1	~	Va	Jall		100	217	222
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	with the M 3e or 28e-f	i Director	10e. Street and Number 604 Tee Jay Ln.	Inorc	Danaai	10f. Zip Code 21222			10g. Citizen o	of What Coun		
5-0036	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. Marked other than "natural", or items 23e or 28e-f ehow imatic event, the Medical Examinar mais be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub 1 □ Yes 2 ☑ No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- no Rican, etc.)	В	ace - Americ lack, White, cify: Whi	etc.	
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	(/		30. Name and address of person who commeliss a Bak	6- 10N. G.	2005	treet Ro	Itmore	MD 2	1701	-100		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 02 2005	32. Registrar's Signa	die de la contraction de la co	U						

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 29 MAY 2006 7:03am /Medical Ronald Cassidy 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 228-58-8497 June 9,1948 57 Director Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other then "neturel", or Items 23s or 28e-1 show other treumatic event, the Modical Examinar mini be notified at Maryland Charles LaPlata 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Hickory Lane #408 20646 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Pivorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then * Elementary/Secondary (0-12) College (1-4or 5+) Pruner Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Cassidy III Hazel King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Drive, Newburg, MD 20664

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Date Carol Casey, Sister 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oregon Funeral Srvc. 06/01/06 Portland, Oregon 22. Name and Address of Facility Harman Funeral Service, P.A. 21. Signature of Fyneral Service Licensee M01113 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conseque of) Examiner Sequentially list conditions, I say, leading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Š 1 ☐ Yes 2 ☐ No 3 Probably 4 @Onknown Completed peed 2 b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: ٩ 1 Tyes 1 Depatient 2 ER/Outpatient 3□ DOA this To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manyer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide To the Hospital or 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number 29d. Da signed (Month, ay, Year) D-37174 30. Fe a deddress of person who completed cause of death (Item 23a) (Type, Print) SONG C. CHON MD 7c POST OFFICE ROAD WALDORF MARYLAND 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 02 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-00

Box 68760,

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bie Brown C	·	1- For State Registrar	e of Maryla		rtment of rtificate of		and	Menta		F	Reg No.	20	06	1736
Physicia dical Exami		1. Decedent's Name (First, Middle, BOBBIE BRO	_{-ast)} WN CAMPB	ELL						Date of De Month May 30, 2	Day	Year		Time of Death 1606 hrs
	7	4a. Facility Name (if not institution, 6700 Belcrest Road, #8	=	ımber)	4	b. City, Tow Hyattsv		ocation of I	Death	_		County of D		
Funeral Director		570 26 5512	Sex	7. Age (In yrs I	ast birthday) 76 Yrs.	If Under Months	1 Year Days	If Under :	24 H rs. Min.	8. Date of B		1930 FG		ashington
nd show any	'n	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George'		Town or Location									d Inside City Limits Yes 2XX No
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ter death with the Maryland ", or items 23a or 28a-f show or must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 XX Divor	A	2 XXNo	If Ye		of Hispa Cuban, M	Mexican, P		eify Yes or Nican, etc.)		14 Race - A White, et		Indian, Black, White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ompleted by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	or Dates:	de completed)	16a, Decedent during mo		coupation ng life, D	n (Give kir O NOT us	se retired	d)		Kind of Busine	ess/Indu	stry
1215-0036 I be filed within 7 ental Hygiene arked other than vent, the Medica	Be C	17. Father's Name (First, Middle, L. UNKNOWN						Ag	nes	irst, Middle,	OWN)			
MD 21 nd 2 should alth and Me m 27 is ma	To	19a Informant's Name/Relationship Gregg Campbell			2104	Tram	Roa	d, W		ral Route Nu rf, M	D 20	ity or Town, S 0601		,
Baltimore, Department of Heal Important: If item		20a. Method of Disposition 1 Burial 2 XXCremation 4 Donation 5 Other Specific		om State	Place of Disposi crematory or oth ee Crema	er place)				Date		inton,		n, State
Baltin permit. Departm Importa injury o		21. Signature of Funeral Service Li	ful /	10015	3 A	_{ame and A} lexan	dress ο driε	f Facility Fer	Lee ry R	Euner:	al H	ome In		33 01d
Physician /Medical Examiner		23a. Part I Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease	a. Atheroscle	rotic Cardiov	Do not enter the	e mode of	dying, st	uch as car	diac or n	espiratory ar	rest, sho	ock, or heart	A	pproximate Interval Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	b	a consequence o										
iği ed 🗡	Examine	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	a consequence o									-	
50, te be executed by sician and burial - transit	Aedical I	UNPENDED	AMENDED											
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P.O.	by P	Part II. Other significant conditio	ns contributing t	o death but not r	esulting in the u	nderlying c	ause giv	en in Part	I.			_		cause of death?
ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach	Completed									24a. Was auto perfe 1 Yes	psy ormed?	prior deat	to comp	y findings available oletion of cause of
	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatient		10	f Death (C		ly one) Home 5	Reside	nce 6 🗸 0	ther Sc	ene
Division of Vital Nospital or Attending Physician: 24 hours after death Funeral Director: After this certif rely filled in by the funeral director.	tion: To	1 Y Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Date (Mont)	of Injury n, Day,Year)	28b. Time of In		c. Injury	at Work?	2	8d Describe				5110
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	Certification	2 Accident Investi 3 Suicide 6 Could 4 Homicide	not be 28e. Plac		ome, farm, stree	t, factory, c	ffice bui	lding, etc.	21	8f. Location or Town,		nd Number o	r Rural F	Route Number, City
To the Hosp within 24 ho To the Fune	Medical C	one) 2 Medical Exam	sician: To the be iner: On the basis and manner	of examination a		on, in my o	pinion, c	leath occu			and pla	ice, and due t	to the car	
)	Ź	29b. Signature and title of certifier	AR				D.C.M					Date signed 31, 2006		Day, Year)
17		30. Name and address of person was Zabiullah Ali, M.D. A	no completed caussistant Medic			n Street,	Baltin	nore, MI	D 2120	01				
S	tate	31 Date filed (Month, Day, Year)		egistrar's Signa	Je Aiga	11)								

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** عُكُلُند Ilia AM Devis CHISHOLM 26 MA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Bradford Oaks Nursing Home Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | 1910 | Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Months 1□M QQF Yrs. 219 16 2283 96 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "neturel", or Iteme 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20735 United States 7520 Surratts Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Item eny Injury or other treumatic event, the Medical Examinar once. 1 Yes XX No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify: ģ XX Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Gift Wrapper/Cashier Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Claggett Simmons Myrtle Duffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3495 Pinecone Circle, Waldorf, Maryland 20602 George Albrittain (Son) 20b. Place of Disposition (Name of May 31, 02000 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Trinity Memorial Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licens Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) puenTa Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Decease of July that initiated events resulting in death) Last Due to (or as a consequence of). ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes XXNo certificate has 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes XX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After t Certification: 1 Natural 2 Accident 5 Pending investigation efter death. Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MAY 26, 2006 D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1701 Livingston Road, Fort Washington, many fond T. TANNER MY 31. Date filed (Month, Day, Year) 32 egistrar's Signature State JUN 02 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30, 2006 Cyril Austin Caulk May 7:45 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 601 Morris Ave. Lutherville Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country) Sept. 28,1907 Baltimore, MD. 5. Social Security Number 6. Sex 1 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 98 212-07-6373 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore County Lutherville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Morris Ave. 21093 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Pattern Maker Martin Marietta permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any injury or other treumatic event spag. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Caulk Lula Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Step Dau.) Parkville, Maryland Mrs. Helen Quinn 2600 Wentworth Road 21234 20a. Method of Disposition

1△ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 02,2006 Dulaney Valley Mem. Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2,2325 York Road Timonium, Maryland 21093 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cholu days /Medical Due to (or as a consequence of): uebnoviscular Examiner distage rears if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autoosy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 XNo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

Certificate be executed Box 68760, 745 The law requires that the death o ۵ Records. 2 of Vital To the Hospitel or Attending Physician: Division death.

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filed within 72 hours after death

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Baltimore, Maryland 21215-0036

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certificate To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours after To the Funeral Dire

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29b. Signature, and title of certifier

29a. Certifier

29c. License number DS8303

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Warles St Bannone W

31. Date filed (Month, Day, Year)

32. Posistrar's Signature 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Dorothy Juanita Corsair 2006 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KLUERSI 8. Date of Birth (Month, Day,)
May 22, If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year, 1 □ M 2 F Months Days 141-28-2816 90 New Jersey 1916 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show injury or other treumatic event, the Mudical Exartane must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11345 Pulaski Highway Lot 26 'neturel', or Items 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Item any injury or other treumetr. 1 ☐ Yes 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: À If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aide Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Elsie (unk) (unk) Garoni Kruger Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur L. Corsair - Son 11345 Pulaski Highway Lot 26, White Marsh, MD 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX emation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Hilltop Serv. Corp. 5/31/06 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas List only Immediate Cause (Final disease or condition resulting in death) Priysician N4000 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner -transit and Due to (or as a consequence of): burialphysician a Box 68760. Physiclan/Medical as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 🗌 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à hypertyradis in 1 Yes 2 No 3 Probably 4 Unknown Completed schriphnen's 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 200 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred of or Attending Parties death.

I Director: After Certification: After 5 Pending investigation 1 ANatural 1 🗌 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink

Flease Type of Frint in Black indelible ink		
State of Maryland / Department of Health and Mental Hygiene		0.0
Certificate of Death	Pog No	20

		Registrar Certificat	e oi	r Death_					Reg No	6-		0 1/30
Physicia dical Exami		1. Decedent's Name (First, Middle, Last) JOSEPH CHARLES CORTINA, JR.		·				Date of De Month May 30,	Day 2006	Year		3. Time of Death 0740 hrs
>		4a Facility Name (if not institution, give street and number) 702 A Stage Coach Road		4b. City, Tow Glen Bu		ocation of I	Death			c. County of Anne Aru		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthold $214-50-7913$ $1 X _M$ $2 F 49$	ay) Yrs	If Under 'Months	Year Days	If Under 2 Hours	1.4		,	/DD/YYYY) 1956	Foreign	nplace (State or ntry) MARYLANI
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ᅙ	Armed Forces? X yes 2 No Never Married Armed Forces? X yes 2 No No	RNI 3. Waltry 1 Decedenting m CRA Mailing m Visippose or other seconds.	TE 10f. Zip Co 2 10 (as Decedent res, specify Co 2 X (as Decedent	of Hispacuban, I No cupation g life. E Street a D R of ceme	Mexican, P specify In (Give kin DO NOT us Mother's I EEORG I and Numbe LD . , (etery, LRK	od of worke retired Name (Fi IA L. er or Rura FLEN D UNE 2006	rst, Middle GLA al Route Ni BURN ate 3,	UNI 16b. B, Maider SCOC Jumber, C IE, 20c. GL	White, Specify: W Kind of Bus UILDI Surname) K ity or Town MARYL Location - (TATE America etc. WHITI iness/ine NG State AND City or T	ES an Indian, Black, E dustry Zip Code) 21061 fown, State E, MARYLAND
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	42 nter ti	1 CRA]	ying, su	WY . , uch as card	S.E.	spiratory a	EN B	ÚRNÍE ock, or hear	, MD	Approximate Interval Between Onset and Death
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P.O. I res that the signed by the detacher	ò	Part II. Other significant conditions contributing to death but not resulting in	the u	underlying ca	use giv	en in Part l	l.		_		_	e cause of death?
sion of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death cer death ector: After this certificate has been signed by the attendi by the funeral director, page 2 should be detached for use	Completed						_	24a Was auto perf 1 ✓ Yes	opsy ormed?	pri de		psy findings available mpletion of cause of
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Vita hysici this c	6	examiner? 1 ✓ Yes 2 No Hospital 1 Inpatient 2 ER/Outp	atient	3 DOA	. 0	ther 4 N	lursing H	ome 5	Reside	ence 6 🗸	Other: 8	Scene
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Division pital or Attendit urs after death eral Director: A	Certification	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.	stree	et, factory, of	fice bui	lding, etc		or Town,	State)			Route Number, City Burnie, Md.
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fur	Me i al C	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death nel) 2 Medical Examiner: On the basis of examination and/or inversity and manner stated										
F * F 5	M	296. Signature and title of certifier		1	cense C.M					Date signed / 31, 200		h, Day,Year)
20		Name of address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 F	enn	I Street, B	altimo	ore, MD	21201					
Si Regis	ate trar	31. Date filed (Month, Day, Year) 32 Registrar's Signature	,	10								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 18 per the 8856 6-2-06 Mealth and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** CAPLAN (147 STANLEY 2006 700 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAI HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 06/11/1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 82 Yrs. MD 219-10-9072 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 23a or 28a-f ehow the Medical Examiner must be notified at 1 V Yes 2 No DELRAY BEACH Director PALM BEACH 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 33446 USA 7341 AMBERLY LANE #310 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) natural', or itema 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED DRY CLEANING permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If Item 27 is marked other the any Injury or other traumatic event, ITEM ONCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HERMAN Be CAPLAN CHARLES JEAN HELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 CLARKS LANE #307 - BALTIMORE, MD 21215 TILLIE CAPLAN / WIFE 20a. Method of Disposition
1 IA Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ARLINGTON CHIZUK AMUNO 6/1/2006 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit SHOR Aprocale that initiated events resulting in death) Last been signed by the attending physicien and should be detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 Ñ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes Lostn divin certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 2 No Certification: To 1 TYes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. naral Director: A investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dute 105

32. Begistrar's Signature

OUD

2006

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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					C	ertificate d	of Death		Reg. No.	00	1 1000
			1. Decedent's Name (First, Middle, La	st)		-		2. Date of D	eeth Day_	Year	3. Time of Death
4	Physicia /Medica		Thomas			Con	roy	Mac		2006	113 Am
,	Examine		4a Facility Name (If not institution, giv	e street and number)	. /		4b. City, Town, or	Location of Dea			
			Oromwell	Nuvsin	l- 1-100	mo	Sa	lome	ne	N/A	
	Funeral		5. Social Security Number 6. S		n yrs. last birthd	y) If Under 1 Y			rth	9. Birthp	place (State or Foreign
	Director		213-09-8388	M 2□ F 9	4 Yrs	Months Da	ays Hours Min		1,1911	Marv	/land
			Usuel Residence of Decedent								
	ylen Maria		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	the Merylen 28a-f show notitied at	ģ	Maryland Balti	more			Parkvil	le			1 ☐ Yes 2 /[] No
	r 284	<u>8</u>	10e. Street and Number			10f. Zip Cod			10g. Citizen of	What Cour	ntry?
	23a or	9	3204 Rosalie Av	e.			21234		Unite	d Sta	ites
	items 2	Funeral Director	11. Marital Status	12. Was Decedent E	ever in U,S. 1	3. Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N	o- 14. Ra	ce - Americ	
0	fer fer fer fer fer fer fer fer fer fer	2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N				το Hican, etc.)		ck, White,	etc.
070	urs e	2	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2ᡚ	No Specify:		Specif	y :	White
21215-0020	n 72 hours effer death with the Meryland "naturel", or items 23a or 28a-f show adical Examiner must be notified at	Be Completed by	15. Decedent's Ed	ducation	16e. De	cedent's Usual O	ccupation	-dela-	16b. Kind of B	usiness/Inc	dustry
215	c = 30	Be	(Specify only highest gra	College (1-4or 5	- (G	ive kind of work di B. DO NOT use re	one during most of wo stired)	orking			
7	within jiene.	E	12 Years	College (1 4015		Metal Wo	rker		Steel	Indu	strv
	at the	9	17. Father's Name (First, Middle, Last,	1	·		18. Mother's Na	me (First, Middle	e, M aiden Sumar	пө)	
an	d be sentel	10 B	Thomas Conroy				Mary	Thomas			
Maryland	and M	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (St	reet and Number or F		ber, City or Town	, State, Zip	Code)
× ×	d 2 is		Mrs. Audrey Neuk	am (Daught	er) 200	O1 Codd 2	Ave. Dund	alk, Mai	ryland	21222	
Ġ,	Heal Heal em 2	- 1	20a. Method of Disposition		20b. Place of Di	sposition (Name o	of .	Date	20c. Location	- City or To	own, State
٥	nt of nt of or or or or		NBurial 2 ☐ Cremation 3 ☐			rematory or other		c	Dallada		N
Ë	than tant	1	4 Donation 5 Other (Specif	The state of the s	Parkwood		cy 6/1/200				Maryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryle Department of Health end Mentel Hygiene. Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-4 show important: If Item 27 is marked other than matter than Madical Examiner must be notited at and Injury or other traumatic event, the Madical Examiner must be notited at ance.	- 1	21. Sunature of Funeral Service Licer	isee	Ω	Duda-Ru	ddress of Facility ck Funeral	Home of	Dundal	k, In	C.
	00580	_1	1)2	. (a	ex		se Ave. D				222
		\neg	23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not	enter the mode of	dying, such as cardia	c or respiratory	arrest,	1	Approximate Interval Between
J. Salar	Physician				Λ		1			1	Onset and Death
_	/Medical		Immediate Cause (Final disease or condition	(a	rdiac	PYY	hy 14 mi	a			
	Examiner		resulting in death)		Due to (or as a con						
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	icete be executed physician and s the bunel-trensit	edical Examiner	Sequentially list conditions.	b	Due to (or as a con	sequence of).					
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68760	ertificete be execut ling physician and e es the buriel-trer	Ca	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or as a con:	sequence of):	*			-	
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X	ettending for use ex	Š	•	d							-
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0	the cy y the	Ş	Part II. Other significant conditions of	Sitting to death bo	it not resulting in the	e dilderiying cadsi	gwon in rate.		Yes 2□No	3 ☐ Prot	
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Ö	requ	e						perl	ormed?	COI	ailable prior to mpletion of cause
še	2 8 8	Completed							_/		death?
=	The sete h	ខ្ច						10	Yes 2 No	1 [☐Yes 2☐ No
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of\	6 6 -	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatie					idence 6 □Oth		v)
2	ding Phy h. After thi funeral	Ë	27. Mannef of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injui		Injury at Work?	28d. Describe	how injury occur	red	
Division	Attanding in death.	ig	2 ☐ Accident investigatio			М	1 Yes 2 No				
<u>×</u>	er de	≝	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Inju	iry - At home, farm, . (Specify)	street, factory, of	fice		(Street and Numi own, State)	per or Rura	I Route Number,
	s effe	Ce									
	To the Hospital or Attandi within 24 hours effer death. To the Funeral Director: A completely filled in by the to	edical Certification:		ysician: To the best oniner: On the basis of							
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	within 2 To the comple	Ž	29b. Signature and title of certifier	>		29c_Li	cense number	_	29d. Date signe		
			1 / STOMA	11.10	10	1/1	205985		May	30	2006
	1	}	30. Name and address of person who	completed cause of de	eath (Item 23e) (Tvi	pe, Print)	,	1	J-	-	2
	(0		Winghin (SMC	mn	5601	Lock	Pare	n BlV.	& MI	12/0	293
	Stat		31. Date Wed (Month, Day, Year)	32. Registra	n's Signature	Secoll :	, , , , , ,	. 10.1	, ,,,,		
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		-	For State Registrar		State of	f Marylan	•			ealth a Death	ind Me		giene Reg. No		6	1736	9
8			1. Decedent's Name (Fi	irst, Middle, Las	t)							2. Date of De Month	Day		'ear	3. Time of Dea	ath
	Physicia /Medic	al			ert Edwa		ine, S					May 29				1:55 A	М
Service	Examin	er	4a. Facility Name (If not		street and nun	nber)		4b. City,		Location o	f Death		4c.	County of Balt		ro	
- 50	£***	\$0 m	1906 Church 5. Social Security Numb		ax .	7. Age (In yrs.	iast birthday)	If Unde	Dund r 1 Year	If Under 2	24 Hrs.] 8	B. Date of Bin	th			lace (State or Fo	oreian
	Funeral Director		236-56-59	12	Д М 2□ F	67	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb.				try) Virgin	
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	vith th	Dire	10e. Street and Numbe	_	.d			10f. Zij	p Code	212	22			izen of Wh			
	s 23g	erai	11. Marital Status	arch not		edent Ever in U	S 13	Was Dece	edent of Hi	ispanic Orio	nin? (Spec	ifv Yes or No		ited			
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f ehow event. If a Medical Examination and the retiliant	by Funeral Director	1 Never Married 3 Widowed 4		Armed Fo	rces?	1	If Yes, spe 1 ☐ Yes		Specify:	, Puèrto R	ify Yes or No ican, etc.)		Black, Specify:	White, e	otc. White	
2-0	72 ho natur	Completed by	15. (Specify o	. Decedent's Ed	ucation de completed)		16a. Dece	dent's Usu	al Occupa	ation during most	t of working	7	16b. K	ind of Busi	ness/Ind	iustry	
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Ž	should be I and Mental I marked o	၉	19a. Informant's Name				19b. Maili	ng Addres	s (Street a	and Numbe	er or Rural	Route Numb				Code)	
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ē,	ges 1 and 1 tof Health If item 27 or other tr		20a. Method of Disposi			,	Place of Dispo	sition (Na	me of	:e)	Da	ite	20c. L	ocation - Ci	ity or To	wn, State	
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Baltimore,	permit. Pages Department of t important: If it eny injury or of		21. Signature of Amer	/ pl	Kell			Duda-	-Ruck	e Ave	eral Du	Home o	, Mai	ndalk rylan	i, II	nc. 1222	
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687	ficate physics the	edicai			a								-				
Вох	eath certificate be executed attending physicien and for use as the burial-transit		IF FEMALE: 23b. Was decedent pro	egnant	23c. If yes, out	come of pregn	ancy	75						23d. Date	of delive	ry	
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 mo 1 ☐ Yes 2 ☐ N	nths?		ointh 2 ☐ Feta nant at time of o		□Ectopic p □ Other (s						Month	ר	Day Year	г
P.0	at the by th	hys	9 🗆 Unknown														
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Records,	w require should	ted										1 🗆	Tes 2	3	☐ Prob	ably 4 □Unkr	IOWII
ec	alaw asb esst	Completed										24a. Was		pri	ere autop or to con ath?	psy findings avai npletion of causi	ilable e of
E H												1 □ Yes	2 No		Yes	2 🗌 No	
Vite	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred examiner?		Hospital:		3 = D (0 · · · ·		Oth	00		Check only		. 50.			
of Vital	Phy rald	5 T	1 ☐ Yes 2 No 27, Manner of Death		28a. Date	Inpatient 2 ☐ of Injury	28b. Time o		28c. Injun Wor	4 🗆 NU		e 5 Resi				"	
on	Attanding r death.	盲	1 Natural 5 2 ☐ Accident	5 Pending investigation		th, Day Year)	Injury	М		k? Yes 2 🗍	No						
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ā	tai or s afte ai Dir ed in l	Certification:	- Litornicide		Dalla	ing, etc. (Speci						2, 0. 10	, Grate				
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 18 (Check only 25 one)	Certifying Ph	niner: On the b												
	To the To the Comp	Z	29b. Signature and file	e of certifier				29	9c. Licens	e number			29d. Da	te signed (Month, I	Day, Year)	
			P 1/21	alah	,				177	046	6		5	50	106	>	
	1.+1		30. Name and address	of person who	completed caus	se of death (Ite	m 23a) (Type	Print)	ari	1 F	SIVI	N	141	TE N	IAP	CH K	4
-	V		31. Date filed (Month,	Day, Year)	1 / H 32 F	Registrar's Sign		11 11	DEL	- +-	VL	- /	-[17	101	1/1/	212	136
	St: Regist			2 2006	Books	J.	BORAN										

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Ma	•		nt of H	ealth and			006	17370
			1. Decedent's Name (First, Middle, Lo	ast)					2. Date of D	eath		3. Time of Death
п	Physici		TREVA LEE CHA	VIS					Month MAY	29	, 2006	2:00 A ^M
1	/Medic Examin		4a. Facility Name (If not institution, gi			4b. Ci	y, Town, or	Location of Dea	th		ounty of Death	1 = 3.3.3.33
			STELLA MARIS			TI	MONI	JM		В	ALTIMO	
	Funeral			Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. last birt	Month	ler 1 Year s Days	If Under 24 Hr. Hours Min	(Month, D	rth ay, Year)	9. Birthp Cour	place (State or Foreign
	Director		212-46-3985	TOM ZEEF	68	Yrs.	<u></u>		06/	0.5/19	37	NC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					1	0d. Inside City Limits
	Aaryli f eho	ō	MD		DATES	MODE						1 XYes 2 No
	the f	ect	MD 10e, Street and Number		BALTI		Zip Code			10g. Citize	en of What Cour	ntry?
	With With	Funeral Director	2225 E. LOMBA	DD CM		2	1231			USA		
	me 2	era	11. Marital Status	12. Was Decedent	Ever in U.S.			ispanic Origin? (Specify Yes or N rto Rican, etc.)		I. Race - Amend	can Indian,
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces?	No		ecity Cuba 2 ⊠ No		no Hican, etc.)			RICAN
8	ral", c	l by	3 ☐ Widowed 4 ☐ vivorced	If Yes, Give Year or Dates:		TO THE	2 221 NO	эрөспу.			Specify: IND	OIAN
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ha Medical Examiran must ke motified at	Completed	15. Decedent's £ (Specify only highest g		16a.	Decedent's U	work done o	during most of we	orking	16b. Kini	d of Business/In	dustry
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	filed v Hygie other t		8TH 17. Father's Name (First, Middle, Las	e)	HC	MEMAK	EK	18 Mother's Na	ame (First, Middle	HOM.		
Maryland	Mental Harked of	Be	HARIS CHAVIS	•,					OXEND		arriamo)	
Ž	should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship	(Type Print)	19b.	. Mailing Addre	ss (Street a		Rural Route Numi		Town, State, Zio	(Code)
Ma	d 2 sho th and t7 is ma traum		DAVID OXENDIN			14 NO			ALTIMOR	-		
ā,	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Heath and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23s or 28s-f ehow or other traumatic event, Ira Madical Examinar must be notified at		20a. Method of Disposition	11, 5011	20b. Place of	Disposition (A	lame of		Date		ation - City or To	
JO.	ages ant of it: If I		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		OAKLA	y, crematory`o WN CEN			02/200	i B	ALTIMO	RE MD
Baltimore,	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Lice		/							FRNL. HM
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused	the death. Do r							Approximate Interval Between
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	ecute and -trans	Examiner	that initiated events resulting in death) Last	C. Dua to (or an	a consequence	of):						
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×6	ding	/We	IF FEMALE:	23c. If yes, outcome	of pregnancy			2000		25	d. Date of delive	20/
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death time of death	3 ☐Ectopic 5 ☐ Other					Month	Day Year
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	The law requires that the death certifica tite has been signed by the attending phoage 2 should be delached for use as the	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlyin	cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of death?
ğ	w require been sig should b	ed t							1 🗆	Yes 2□	No 3□Prob	ably 4X Unknown
Records,	aw requise been 2 should	Completed							24a. Wa	s an	24b. Were auto	psy findings available mpletion of cause of
Ĕ	The ate his page	ĕ							pert	ormed? 2 X No	death?	
Vital	sien: artific ctor,	Be (25. Was case referred to medical examiner?				-		eath Check only	one)		
of V	Physicien: r this certific ral director,	ပ္	1 ☐ Yes 2 No	Hospital: 1 Inpatie	-	·		4 Nursing				W HOSPICE
Ē	ing P	o	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. 1	Time of njury	28c. Injun World		28d. Describe	how injury	occurred	
Sic	Attending r death.	cat	2 Accident investigati 3 Suicide 6 Could not	be One Bless of Ini	um. At home fo	M step at to at		Yes 2 No	29f Location	(Stroot and	Numbos os Ouss	al Route Number,
Division	or Al after of Direction by	arti	4 Homicide determine		ury - At home, fa c. (Specify)	im, street, raci	ory, onice		City or To	wn, State)	NUMBER OF MUTE	ii noble ivumber,
_	Hospitel or 24 hours afte Funeral Dir tely filled in	2	29a. Certifier 1X Certifying F	Physician: To the best	of my knowledge	a. death occurr	ed at the tin	ne date and plac	e, and due to the	a cause(s) a	nd manner as s	tated
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	(Check only 2 Medical Exp	aminer: On the basis o and manner st	f examination an-	d/or investigati	on, in my o	pinion, death occ	curred at the time	, date and p	place, and due to	the cause(s)
	To the within 2 To the complete	₩.	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			1	-			DY	3725		6	5/30/0	6
_	2		30. Name and address of person wh	o completed cause of c	leath (Item 23a) ((Type, Print)						
_	C7		DR. TARIQ MAHMO		ULANEY V	ALLEY	RD.	TIMONIUM	, MD 210)93		
		ate	31. Date filed (Month, Day, Year) JUN 0 2	32. F istr	ar's Signature	10000						
~ 14	Regist	rar	2011 0 2	ZUUD Jag	us IR	Book	1					

State of Maryland / Department of Health and Mental Hygiene UU5 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2006 Year May 29 **Physician** JoAnne Η. Day 2:02 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 7177 Eastbrook Ave. Months Days Hours Min. 8. Date of Birth (Month, Day Year) 950 Birthplace (State or Foreign Country)
_ 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 216-54-3946 1 M 200 56 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ir than "natural", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at Baltimore Baltimore MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 7177 Eastbrook Ave. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) own home other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 9th item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental Hitant: If item 27 is marked other. Myrtle Himes John Kaptian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7177 Eastbrook Ave. Baltimore MD Charles T. Day /husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Holy Redeemer 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 6/2/06 4 ☐ Donation 5 ☐ Other (Specify) important: any injury c permit. Departr 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 complications that caused the de Part1. Enter the disease, of comshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably 4 Unknown been signature Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has b page 2 s autopsy certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 1 No 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No Il Director: A investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funaral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number ause of death (Item 23a) (Type, Print) Sheet, Balt more, r istrar's Signature State Registrar

DHMH 17 Rev 1/2001

ı			1 - For State Registrar	State of Maryland / Dep	partment of Health and I partificate of Death	Mental Hygier Reg. N	ZUUD 1/3/7
	Physici /Medi		Decedent's Name (First, Middle, Las DEBORAH	t)	DILWORTH		Day Year 2027 M
	Examir Funeral Director		5. Social Security Number 6. Se	ns Hospital	4b. City, Town, or Location of Death Baltimore Ci 11 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	ty	9. Birthplace (State or Foreign Country) 952 MD
	פ		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		10d. tnside City Limits
	th the Ma or 28a-f	Irector	MD Baltimo	ere City Baltimo	10f. Zip Code	10g. (Citizen of What Country?
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-1 ehow or other treumatic event, the Madical Examinar must be nutified at	by Funeral Director	2038 Gough St. 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 3 ➡ vivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Stroot If Yes, Give Year or Dates:	21231 Was Decedent of Hispanic Origin? (Sitt Yes, specify Cuban, Mexican, Puerton Terror Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	(Given (1-4or 5+)	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired) emaker	king 16b.	Kind of Business/Industry
	rid be filed v fental Hygie rked other t lic event, th	To Be Co	17. Father's Name (First, Middle, Last) Matthew Sinnott		18. Mother's Nam	ne (First, Middle, Maide Bandy	en Sumame)
, Maryland	and 2 should Balth and Men n 27 is marke ler trsumatic	-	19a. Informant's Name/Relationship (7 Sherica Dilwort		ling Address (Street and Number or Ru Stewarton Ct. F	ral Route Number, City Perry Hal	
Baltimore,	Fa Pa		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Chesape	ematory or other place) ake Crematory Inc.	May 31 2006 Be	Location - City or Town, State
Ball	Departri Departri Imports eny inju		21. Signature of Funeral Service Licens	Ruther Molyy3	²² Name and Address of Facility Cremation and Funer 8717 Green Pastures	al Alternat: Drive Balt	ives timore, Maryland 21286
68760, <	Physician pe executed by Physician and Medical Example and previously transit as the partial-transit	edical Examiner	shock, or heart failure. List only of the transfer of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	PATOPULMONARY IRRHOSIS OF TH	SYNDROM	Approximate Interval Between Onset and Death In DAYS 3 YEARS
Box	ie death certii the attending hed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P.O	w requires thet the bean signed by should be detact	þ	Part til. Other significant conditions or	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Records,	n: The law r ilicete has be or, page 2 sh	e Completed	25. Was case referred to medicat			24a. Was an autopsy performed?	
\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{	ysicia s cert directe	To B	examiner?	Hospitat: 1 Inpatient 2 ER/Outpatie	04	th (Check only one) ome 5 \subseteq Residence	6 □Other (Specific)
ion of	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funers! Director: After this certilicate has completely filled in by the funers! director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b. Time Injury		28d. Describe how in	
Divis	itai or Atte irs after de rsi Directo led in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		City or Town, Sta	<u> </u>
	ne Hosp n 24 hou ne Fune bletely fil	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my knowledge, dea liner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause fred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier Culnus Saud Mal.	th, MEDICAL DOCTOR	29c. License number RES-000		Pate signed (Month, Day, Year)
	2		ADNAN MALIK, THE I	completed cause of death (tiem 23a) (Type OHNS HOPKINS HOSPITAL,	600 N. WOLFE STREET,	BALTIMORE,	MARYLAND 21287
DH	Sta Registi	rar	31. Date filed (Month, Day, Year) JUN 0 2 20	32. Registrar's Signature	porte		

			For State Registrar		State	of Ma	ırylanı		artment of F rtificate of			-	giene	006	173	73
	Physici	an	1. Decedent's Name		Last)							2. Date of De Month	_	Year	3. Time of	Death PM.
	/Medic	al	Gloria I		nive street and n	um her)			4b. City, Town, o	r Location o	of Death	5	27	Year O'C County of Death	101	/ M.
	Examin	er	LORI		_	RSI	DE		BEL	CAN	_		H	ARFOR	Z D	
	Funeral		5. Social Security N		6. Sex 1 □ M 2√2 F		10 -	ast birthday,	If Under 1 Year Months Days	If Under Hours		8. Date of Bir	th		place (State or ntry)	r Foreign
	Director		220-22-50 Usual Residence of		ILM AQF			Yrs.				11/28	3/1924	1 MD		
	yland Now		10a. State	10b. County			10c. City	, Town or L	ocation						10d. Inside Cit	,
	the Marylar 28a-f ahow	ctor	MD	Harfor	rd —————		Bel	camp							1 Tes	2. No
	filed within 72 hours after death with the Maryland Hygiene. Athar then "natural", or Items 23a or 28a-f ahow ant, Ite M. Clical Examither must be notified at	Completed by Funeral Director	10e. Street and Nur 1123 Belo		rth				10f. Zip Code 21017				10g. Citize	en of What Cou	ntry?	
)	Jeath Trus 23	eral	11. Marital Status		12. Was De	cedent E	ver in U.:	S. 13.		lispanic Ori	gin? (Spe	ecify Yes or No		I. Race - Ameri	can Indian,	
\\ \alpha \ \\ \\ \\ \ \ \ \ \ \ \ \ \ \ \ \ \	after o	Fun	1 Never Marri	ed 2□ Marrie	Armed F	2 DEN	io		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 25 No	an, Mexican Specify:		Rican, etc.)		Black, White		
5-0036	72 hours 'natural',	d by	3×3 Widowed		If Yes, G Year or	Dates:		40× P	2.					pecify: Whit		
5 7	in 72 n "nat	plete			grade completed	·	,	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation <i>during</i> mosi d)	t of workii	ng	Oil	d of Business/Ir	dustry	
7 (C	d with giene.	Som	Elementary/Seco	ndary (0-12)	College	(1-40r 5-	+)	Offic	ce Manage	r						
	ild be filed lental Hygic ked othar ic avent, II	To Be (17. Father's Name Oliver F									(First, Middle, ia Bell		umame)		
$\bigcup_{j \in \mathcal{I}_{j}} \binom{j}{j}$	ges 1 and 2 should be filed to f Health and Mental Hyg If itam 27 la marked otha or other traumatic avent,		19a. Informant's Na Mark Carr						ng Address (Street N. Hickor				-		Code)	
more,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disp 1 Burial 2	Cremation	3 □Removal from	n State	CE	emetery, cre	osition (Name of matory or other place ke Cremat			Jun 2 2006		ation - City or T		d
Baltii	permit. Pag Department Important: any injury o		21. Signature of Fu	-		M	1144		2. Name and Addre Tremation 8						vland 2	1286-
			23a. Part1. Enter the	he disease, or o	complications that	caused	the death		ter the mode of dyir					,	Approximate Interval Bety	
	Enysician	8 14	Immediate Cause disease or condition	(Final	. /	2an	lan	res	diten	0/0	20	ston	90		Onset and D	eath
	/Medical Examiner		resulting in death)		Due to	o (or as a	consequ	ence of):		(-				
		er	Sequentially list co	nditions,	b. Due to	o (or as s	a moneaqu	ienes of):								
./	be executed sician and burial-transit	Examiner	Sequentially list containly, leading to in cause. Enter Under Cause (Disease or that initiated events	rtying injury	c.											
٧,	ate be executed hysician and the burial-transit		resulting in death) I	Last	Due to	o (or as a	consequ	ience of):								
8760,	ate hy:	dica		,	d										-	
Box 68	eath certific attending p	/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, o	utcome (of pregna		24				23	d. Date of deliv	erv	
P.O. Bo	To the Hospitel or Attanding Physicien: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	Physiclan/Medical	in the past 12 1 Yes 2 9 Unknown	months? ☐ No		gnant at	2 □Fetal time of de		□Ectopic pregnancy □ Other (specify)	<i>y</i>				Month		ear
	ss that gned b	by PI	Part II. Other signif	icant condition	ns contributing to	death bu	it not resu	ulting in the t	inderlying cause giv	en in Part I.		23e. Did t	obacco use	contribute to t	he cause of de	eath?
ord	w require been sig should b	ted		undt	9,1	Xy,	ente	VII	٩			1 🗆 '	Yes 2. [7	Nø 3□Prol	oably 4 ⊡U	nknown
ec	e lawr has be je 2 sh	Completed	/	ypur	lynia	Su						24a. Was autor	an osy	24b. Were auto	psy findings a mpletion of ca	vailable use of
<u></u>	ician; The l certificate ha rector, page		05.111	, ,								1 Tes		death?	2 🗆 No	
× ×	ysician; nis certifica director, p	To Be	25. Was case referexaminer?		Hospital:	Inpatier	nt 2∏I	ER/Outpatie	nt 3 DOA Oth			(Check only o		☐Other (Specia	iv)	
οľ	ding Phy h. After thii funeral c		27. Manner of Deat		28a. Date			28b. Time o				28d. Describe I			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
sior	Attandin death. ctor: Af y the fur	catic	1 Natural 2 Accident	investiga 6 ☐ Could n	ation				M 1□	Yes 2 □ i	-					
Division of Vital Records,	I or Attand after death Director: J	ertification;	3 🗀 Suicide 4 🗀 Homicide	determin	ned 28e. Plac	ce of Inju ding, etc	iry - At ho (Specify	me, farm, st	reet, factory, office		2	28f. Location (S City or Tox		Number or Run	al Route Numb	per,
_	To tha Hospital or I within 24 hours after To tha Funaral Dire completely filled in b	edical Co	29a. Certifier (Check only one)	1 Certifying	xeminer: On the	ne best of basis of anner sta	examinat	wledge, dear ion and/or ir	h occurred at the tire to the tire of the	πe, date an	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner as s lace, and due t	tated. the cause(s)	
_	ro tha within Fo tha comple	Med	29b. Signature and	title of certifier	A /	4			29c. Licens	e number			29d. Date	signed (Month,	Day, Year)	
	- >- 0			7 6	1/11	M	me	7	D2	792	T		5/	40/06		
	2		30. Name and addr	eun,	who completed car	use of de		23а) (Туре	Print Mac /	rail	ad	Bal	Dir	Mno	21014	
:	Sta Registi		31. Date filed (Mon	th, Day, Year) [Registra	ır's Signat	ure	hart.							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Marylan	-	artmen <i>tificat</i>			and M	lental Hyg	iene	16	17374
	Physici	an	1. Decedent's Name <i>(First, Middl</i> e, Last Leo	Roge	or		Erke				2. Date of Deat May 25,	2 0 06	Year	3. Time of Death 11:45PMM
	/Medic Examin	cal	4a. Facility Name (If not institution, give					Town, or	Location o		11dy 25,	4c. County	of Death	11.431FIM
	Exami	ler	Calvert Memorial		*				Frede			Calv		
	Funeral Director		5. Social Security Number 6. Se 395-16-4127	x 7 3 M 2 □ F	Age (In yrs. 84	last birthday) Yrs.	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day, April 4	, 1922	9. Birthp Court W1S0	lace (State or Foreign htry) CONSIN
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Mary a-f sho	tor	Maryland Prince G	eorge's		C	linto	n						1 ☐ Yes 2√☐ No
	or 28	Oirec	10e. Street and Number				10f. Zip				1	Og. Citizen of V		itry?
	s 23a	erai	9702 Glen View Dr	ive 12. Was Decede	nt Ever in II	C 12.1		0735		nin 2 (Cn.	aifu Vaa aa Na	USA		en la dia-
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinational benefitted at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ⊒No 19	44-	Yes, spec		Specify:	gin : (Spe i, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White, % Whi	etc.
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usua kind of wor			of worki	na	16b. Kind of Bu	usiness/Ind	dustry
121	within ane. than "	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Offi	OO NOT us	e retired)		S. 1101111		USAF Re	t.	
19	filed withi I Hygiene. othar than	Be Co	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, M			
ylar	2 should be f and Mental b Is marked of aumatic eva	To B	Henry Er	ke						know				
, Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, ILAM DICE.		19a. Informant's Name/Relationship (7) Karen James (Daug			9702	G1en	Vie	w Dri	ror Rura ve C	Route Number. Clinton,	City or Town, Mary la	State, Zip nd 2(Code))735
Baltimore,	Pages 1 nent of He int: If itan		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			lace of Dispo: emetery, crem lingto:				luly	21,	20c. Location -		wn,State Virginia
altii	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Licens		1 2.2		. Name an				e Funera			
<u> </u>	8258		Jano J. Aras		257					dria	Ferry 1	Road C1		. MD 20735
Section Section	Pnysician /Medical Examiner		23a-Part1. Enter the disease, or compishock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or a	S D1° as a consequ	ya+1	ON.	-			MOV 1'Q			Approximate Interval Between Onset and Death
8760, 1	icate be executed physician and s the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated see on the cause of the	s	as a consequ									
P.O. Box 6	The law requires that the death certificate has been signed by the attending place as should be detached for use as to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pre Other (spe					23d. Date Mor	e of delive	ry Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	-	but not resu		derlying ca	ause give	n in Part I.					e cause of death?
Vital Records,		Completed	Hyperkalen	71'4							24a. Was an autopsy perform	ed? P	rior to corr eath?	sy findings available apletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	Check onl one			
of	Phys this ral dii	To To	1 Yes 2 No	28a. Date of Ir	njury	ER/Outpatient 28b. Time of		A Other Bc. Injury Work	4 LI NUI		ne 5 Resider)
ion	Attanding I r death. actor: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, E	Day Year)	Injury	М		? es 2 □ N			, ,		
Division	Dir.	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify	me, farm, stre	et, factory,	, office		2	8f. Location (Str. City or Town,	eet and Numbe State)	er or Aural	Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 ☐ Certifying Phy cone) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the bes ner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	place, a	nd due to the ca ed at the time, da	use(s) and mar te and place, a	nner as sta nd due to	ited. the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	C . /	h	an.			065			d. Date signed		
1	X		30. Name and address of person who co	le ch	use	uton	Print) G	XIA	10 -	C. Dea	SU12;	カントラ	207	51
- Mig-	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 20	106 32. F	strar's Signat	le d	medi	,						

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month May Emelio. Joan 29, 2006 1:04 РМ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth
(Month, Day, Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2 🗓 F Hours Year 70 Director 578-46-3847 Yrs. 1935 Washington, D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State or 28a-f show 10d. Inside City Limits Examiner must be notified at Director Maryland 1 ☑ Yes 2 ☐ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 501 Woodston Road 20850 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Completed by Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced netural', The Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) then al Hygiene. Clothing College (1-4or 5+) Seamstress Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental ? Is marked of James Emelio ပ Edna C. Lees 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Herman R. Earp /Husband 501 Woodston Road, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 2, 20c. Location - City or Town, State Department of the Important: If its eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2006 Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Ungeletter Darriot M01305 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 48 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month 4☐Pregnant at time of death Day Year P.O. I 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate has t lirector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🖾 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 X No 1 🛚 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury death. i Director: A d in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funeral Direct filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58681 May 29, 2006 ned cause of death (Item 23a) (Type, Print) Jude Alexander, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 gistrar's Sign 31. Date filed (A 32. 2 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decadent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 46. County of Death Examiner If Under 1 Year If Under 24 Hrs Social Security Number TIMOR 6. Sex 5. Social Security 1325 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral O Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specity: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 192 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royle Number, City or Town, State, Zip Code) Depertment of Heelth a Important: If Item 27 Is any Injury or other trac 20c. location - City & Town, State 20a. Method of Disposition flace of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Baltimore 1106 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses eand Agolfess by Aller natives tuneral and cremation lork rd. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ignant Physician disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown within 24 hours after death. To the Funerel Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 3 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 28 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Dentural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Suite 209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) endall Rtaullenes WD 6565N, Charles Street

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** May 29 2006 6:01 P Leroy John Flury, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days XXM 2□F Hours 213-30-0635 Director Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County "natural", or itema 23a or 28a-f show idigal Examiner cust be notified at Dundalk 1 ☐ Yes XXNo Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If flam 27 is marked other than "natural", or linear any injury or other traumatic event. United States 21222 Funeral 1947 Church Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Grocery Salesperson 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Hennigan John A. Flury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland 21222 Mrs. Gertude L. Flury (Wife) 1947 Church Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 6/2/2006 Dundalk, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 6074 Approximate Interval Between Onset and Death Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congastive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of). Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1 🗌 Yes Division of Vital 2 1 NO Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direct 4 | Homicide 29a. Certifier 1 Vertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of pertifier 016,941 mul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crossroud Dr Ouinn mills muzili 5 BA18

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:5 aLiah Dineasha 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mexical Da mor W If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Min. Months Days Hours N/A Director ΜĎ Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Heath and Mantel Hyglene.
ant: If item 27 is marked other then "natural", or items 23e or 28e-f show ant: If item 27 is marked other then "natural", or hitems 25e or 28e-f show any or other treumsite architised at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21211 4423 Newport Ave Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Yes 21 No Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Taliah Edwards Andre Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taliah Edwards-Ward-Mother 4423 Newport Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges Depertment of Important: If it eny injury or c tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/31/06 Zion Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av 21215 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician me /Medical Due to (or as a consequence of) Examiner psis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the deeth certificate be executed physicien end s the buriai-trensit new mon 1a Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s Yes 2 No 2 🗆 No 1 Tyes SDIvision of Vital director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending deeth. investigation М 1 ☐ Yes 2 ☐ No i Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide pellij 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

29d. Date signed (Month, Day, Year) 0

06-03340 Byron C. Grant

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

C. Grant		Registrar		of Death	R	eg. No. 200	6 173				
Physicia cal Exami		1. Decedent's Name (First, Middle,Last)			2. Date of Dea Month	Day Year	3. Time of Death 1920 hrs				
Lai Exaiiii	Hei	Byron C. Grant 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location o	May 17, 2	4c. County of Deal					
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year If Under	er 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi					
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and 2 should be filed within 72 hours after death with the Maryland teath and Mornell Hygeine House them 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,		 14 Race - Ame White, etc. 	rican Indian, 8lack,				
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ysician		23a. Part I. Enter the disease, or complications that caused the death.	. Do not ente	er the mode of dying, such as ca	ardiac or respiratory arr	est, shock, or heart	Approximate Intervi				
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic	Cardiov	ascular disease			Between Onset and Death				
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al or / s after l Dire	Certification:	Suicide Could not be determined (Specify)	ome, rann, s	street, factory, office building, etc	or Town, S	Street and Number or R state)	ural Route Number, City				
lospita hour: unera ly fille		29a. Certifier 1 Continue Physician. To the best of my knowled	death or	occurred at the time, date and pla	ace, and due to the cause	ca(s) and manner as ste	urtad				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination a									
To with	Mec	and manner stated. 29b. Signature and title of certifier		29c. License number		29d Date signed (Mo					
		Qual :		O.C.M.E.		May 18, 2006					
		30. Name and address of person who completed cause of death (Item	n 23a)								
		Ana Rubio MD. Assistant Medical Examiner		n Street, Baltimore, MD	21201						
S	tate	31. Date filed (Month, Day, Year) 32. Registar's Signatu	ure	4							
Regis		JUN U 2 2006 Klosus	K	Socie							
1 17 Rev 1/:	2001	, 4,400	ORIGI	NAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19a per fh 9856 6-2-06 vt

State of Maryland / Department of Health and Mental Hygiene)

1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2006ar Robert Martin Geidner 8:06 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore County 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex-1☐M 2☐ F **Funeral** 301-56-8051 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-f show other treumatic event, the Medical Examination must be notified at Maryland Baltimore County Upperco 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3006 Benson Mill Road 21155 United States Funeral 12. Was Decedent Ever in U.S. Anged Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Greater Baltimore Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Clinical Lab Manager 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flie.
Department of Health and Mentat Hy
Importent: If item 27 Is marked other
any injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) William Michael Geidner Betty Gene Hindle 19a. Informani's Name/Relationship (Type, Amtoniotti Mrs. Roberta Geidner—Antoniatti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3006 Benson Mill Road, Upperco Maryland, 21155 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)
Greenmount Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-01-2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr.P.A.
2325 York Road Timonium Maryland, 21093 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancla fic 40412 Cancer resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 s has autopsy performed? 1 Yes 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Medical Certification: To 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deatl Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DOD 61/99 Ma May 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sason Black TOWSON, MD 21204 31. Date filed (Month, Day, Year) State 32. gistrar's Signature JUN 02 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 4b.c per dyr 9856 6-2-06 vt. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** een 7:00 4 M /Medical 4b. CitONSON ocation of Baltimore County of DEALTIMORE Facility Name (If not institution, give street and number) Examiner OWSO If Under 1 Year If Under 24 Hrs. Date of Birth Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 12M 20F 8 9 -16-Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 🖼 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ØYes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Whit 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) Special Imprint Manager Dwect

18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, QDGS. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ဥ chberc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/084 19a. Informant's Name/Relationship (Type, Print) 2005 currettsville 20c. Location - City o Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State -31-06 Paltimore, mD 5 4 □ Donation 5 □ Other (Specify) emekry 21. Signature of Funeral Service Ligense 22. Name aggress of spilly lematives runeral and 325 2 Yorkrd. Timunium, mi) unuelly (Al proximate Interval Between Onset and Death 23a. Part1. Enter the dise ye, or completings that caused shock, or heart failure. List only the cause on each lin e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Jenite Jementila Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the attending physician and hed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by rtensian 212No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No this certificate 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical ASS STED Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: Medical Certification: To 1 🗌 Inpatient 6 Other (Specify) 2 ER/Outpatient 3□ DOA LIVING 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending To the nous after death.
within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MAY, 30, 2006 X 30. Name and address of person who con cause of death (Item 23a) (Type, Print) 51 BHTIMORE MA 21204 670 MARY MA 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 2 2006 Registrar

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DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and	Mental H	ygiene	106	17382
			1 - State Registrer Certificate of Death	1	Reg. No.		T
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	Day	Year	3. Time of Death
	/Medic		FRANCES K. Grimm	111144		1006	1:05 P. M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ın	4c. Cour	nty of Death	–
Ļ			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8 Date of B	Lirth DT		nuke)
	Funeral Director		1 M 2 DF Yrs. Months Days Hours Min		Day, Year)	M A D	ntry)
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	show		10a. State 10b. County 10c. City, Town or Location			1	IOd. Inside City Limits
	Mai	ctor	MD BALTIMORE ROSEdale				1 ☐ Yes 2 ☐ NO
	or 28	Jr.e	10e. Street and Number 10f. Zip Code		10g. Citizen o	of What Cour	ntry?
	23a	Funeral Director	8119 ROSE HAVEN Rd. 21237		L	ISA	
	tens Fens Fens Fens Fens Fens Fens Fens F	une.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 tf Yes, specify Cuban, Mexican, Puel	Specify Yes or Note Rican, etc.)	lo- 14. R B	ace - Americ lack, White,	
9	s afte	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No I □ Yes 2 □ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Spec	city:	rite
3	within 72 hours after death with the Maryland ene. Itan "naturel", or Items 23a or 28e-f show Tre M. Jical Examiner must be notitied at	pa pa	3 UWidowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of	Business/In	dustry
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7	with jene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)		at	hom	e.
2	be filed with ital Hygiene id other tha event, Itte A	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Midd	le, Maiden Sum	ame)	
<u> </u>	uld be Aenta Aenta rked ric e	To E	UNKNOWN Lang Clis	zabet	h Buc	· KSK	rire
<u>a</u>	2 should and Menis is marke	1 3	19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or R	ural Route Num	ber, City or Tow	m, State, Zip	Code)
Ξ.	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f show if item 27 is marked other than "naturel", or items 23a or 28e-f show or other traumatic event, if it M. Alcal Examinar must be notified at		Joseph Grimm-son 8119 Rose Haven 1		sedal	emi	21231
ole	of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location	n - City or To	own, State
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ğ	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	AUTMOR	E. MO		
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. Listonly one each line.	/	1	_	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
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ם.	deat e att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)		^	Month	Day Year
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ō	Physicien: r this certific ral director,	.T.	1 Yes 2 No rushid: 1 Inpatient 2 ER/Outpatient 3 DOA Variet: 4 Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 Re	sidence 6 C		ý)
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S	al or / after I Dire	Certification;	4 Homicide building, etc. (Specify)	City or T	own, State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place				
	he Ho in 24 he Fu pletel	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occords and manner stated.	urred at the time	e, date and place	e, and due to	o the cause(s)
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			I will the the the the the the the the the the		190	9 3	12006
	3		30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) XAUZHUN 500 LOCAROVAN BLUCK	707	Beely	4ms	e 21259
		ate	31. Date filed (Months Day, Year) 322 legistrar's Signature				
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Physicia	ın/	1. Decedent's Name (First, Middle,Last)			····	-	2. Date of De Month	eath Day	Year	3. Time of Death
∕ledical Exami		HARRY THORNTON GI 4a. Facility Name (if not institution, give			4h City	Town, or Location of Dea	May 24,	2006	County of Death	0450 hrs
		4111 6th Avenue	street and number)			more	201	1	BALTIMOR	
Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last bir		der 1 Year If Under 24H	Irs. 8. Date of t	Birth(MM/	DD/YYYY) 9. Bir Foreig	
Director		213-98-3899 ₁ X	м 2 <u></u> F 3	7	Yrs. Mont	hs Days Hours M	FEB.	4 - 1	969 co	untry) MARYLAN
any	ł	Usual Residence of Decedent 10a. State 10b. County	······································	10c. City, Town	or Location					10d. Inside City Limits
*	ايا	MARYLAND ANNE ARU	NDEL	GAMBRI	LLS					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zi	p Code		10g. Citiz	zen of What Cou	ntry?
hours after death with the Maryland natural", or items 23a or 28a-f sho Ex miner must be notified at ones.		2636 APRIL DAWN WA	Y			.054			CED STAT	
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ter des		3 Widowed 4 X Divorced	f Yes, Give Year	X No	1 Yes 2	2 X No specify:			Specify: WHI	TE
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24 3 7	plete	Elementary/Secondary (0-12)	College (1-4 or 5		SABLED	orking me. Do No 1 dae 1	carea)	N/	/ A	
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	HARRY T. GILLISPI	E. SR.			DOROTH	Y M. CO	NWAY		
- S & S & E	P	19a. Informant's Name/Relationship (Ty		1.4		(Street and Number o			-	
e, MD 2 1 and 2 shou Health and N item 27 Is n		DOROTHY M. GILLESP 20a, Method of Disposition	IE / MOTH		686 EAGL of Disposition (Na	E ST. BALT	IMORE, Date		AND 212 ocation - City or	
S = E = F		1 Burial 2 X Cremation 3	Removal from Sta	te crema	tory or other place CREMATO	e) MA	Y 25, 006		•	LE, MARYLAN
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	ee	1						LE, FIARILAI
Balt permit. Depart Impor	5 8	Scott A. Ruddick (per			421 CR	d Address of Facility Y-RUDDICK F AIN HWY., S	.E., GL	HOME, EN BU	RNIE, M	D 21061
Physician i al		23a. Part I. Enter the disease, or compli failure. List only one cause on each	h line.		ot enter the mode	of dying, such as cardiac	c or respiratory a	rrest, sho	ck, or heart	Approximate Interval Between Onset and
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be es	edic	UNPENDED X	AMENDED ite		FH,G856,6/	/8/06 TT		234	I. Date of deliver	,
3876 rtificat ing ph as the	an/e	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal death	3 Ectopic preg	inancy			Day Year
OX 6876(eath certificate attending physicious eas the b	Physician/	1 Yes 2 No 9 Unknown	4 Pregnant at t	ime of death	5 Dther (Spe	ecify)				
D. B t the d by the		Part II. Dther significant conditions		but not resulting	ng in the underlyin	ng cause given in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
, P.(res that signed be det	d by						- 1 Y	es 2	No 3 Prot	pably 4 🗸 Unknown
ords * requi	Completed							opsy	prior to o	topsy findings available completion of cause of
Recc The lav cate ha	mo							formed?	death?	es 2 No
Vital Recysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	ospital:	. [-]		26.Place of Death (Chec		7	n . d nu	
of Vil Physic er this gral dir	욘	1 ✓ Yes 2 No 27. Manner of Death	I III III patiei		Outpatient 3	DOA Other 4 Nurs	sing Home 5 28d. Describ		nce 6 Other	: Scene
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Division of ipital or Attending Phours after death. Ineral Director: After if filled in by the funcral	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b	28e Place of Ini			y, office building, etc.	28f. Location or Town,		nd Number or Ru	ral Route Number, City
Dispital cours at neral I filled	Cert	4 V Homicide determined	(Specify) FDU				800 block	of Glad	e Court, Balt	
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) 2 Medical Examiner:	n: To the best of my Dn the basis of exan	knowledge, de nination and/or	eath occurred at the investigation, in m	ne time, date and place, a ny opinion, death occurre	nd due to the ca d at the time, dat	use(s) and te and plac	d manner as star ce, and due to th	ted. e cause(s)
To t with To t	Medical		and manner stated.	_		9c. License number			Date signed (Mo.	
		T/ 1 11	16- 11	/		O.C.M.E.		May	24, 2006	
5		30. Name and address of person who co								
2			stant Medical E			eet, Baltimore, MD	21201			
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar	s Signature	Souli					
		TOTAL A W COA			1					

ORIGINAL

			For State Registrar	State of Maryl		artment rtificate			nd Me		giene leg. No.	2006	17384
78	Physicia	an	1. Decedent's Name (First, Middle, Last)			TI DEN				2. Date of Dea		2006 ^{Year}	3. Time of Death
100 H	/Medic	al	DAVID 4a. Facility Name (If not institution, give s	I.	G	ILDEN 4b. City, To	own, or Lo	ocation of	Death	MAY	-	County of Death	8:08 P M
	Examin	er	SINAI HOSPITAL				ВА	LTIM	ORE				N/A
	Funeral Director		5. Social Security Number 6. Sex 215-05-3500		yrs. last birthday) Yrs.	If Under 1 Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day 12/27/	Year)	9. Birth	place (State or Foreign ntry) MD
	/ac		Usual Residence of Decedent		. City, Town or Lo	nation				12,27,	1310		10d. Inside City Limits
	Marylar f ehov	jo	MD 10b. County	100	BALTIMO								1 Yes 2 No
	72 hours after death with the Maryland Instural; or Itema 23e or 28e-f ehow dical Examinar must be notified at	Director	10e. Street and Number			10f. Zip C					-	en of What Cou	ntry?
	eath w	Funeral	6317 PARK HEIGHTS	AVENUE API 12. Was Decedent Ever	in U.S. 13	2121 Was Decede	nt of Hisc	panic Orig	in? (Spec	cify Yes or No-		U.S.A.	can Indian,
9	or Item		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🐧 No If Yes, Give		If Yes, specif	y Cuban,	Mexican, Specify:	Puerto F	Rican, etc.)		Black, White, Specify:	
21215-0036	hours itural,	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual	Occupati	ion				WH.	TE ndustry
215	으 근원	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	kind of work DO NOT use	done dui retired)	ring most	of workin	g	T D.	ANOLE D	LIGHTOR
d 21	filed Hygi ther		17. Father's Name (First, Middle, Last)		OWNE	K	1	8. Mother	's Name	(First, Middle,		ANGLE P	LASTICS
/lan	0 0 0 0	To Be	ABRAHAM		GILDEN			REBE					IRKIND
Maryland	and and is m		19a. Informant's Name/Relationship (Ty PAULINE GILDEN /	pe, Print) WIFE	19b. Maili 6317	ng Address (PARK H	Street and	ITS A	r or Rural VE. 1	APT.#51	or, City or 0-BA	Town, State, Zi LTIMORE	, MD 21215
ore,	0 0		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ F	lemoval from State	Ob. Place of Dispo cemetery, cre	matory or oth	ner place)			ate		cation - City or T	
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	В	ETH EL M							DALLSTOW	
Ва	Depa Impo any i		Roberto / 5	7								& BROS., SVILLE,	MD 21208
	Ó;		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the ne cause on each line.				٠.			røst,		Approximate Interval Between Qeset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alute (My (ac	dial	In	tavet	700	$\widehat{}$) unnutits
	Examiner		Sequentially list conditions, if any, leading to immediate	D									
\/	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	nsequence or).								
,160,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	I Exa	resulting in death) Last	Due to (or as a cor	nsequence of):								
6876	ficate by physic ts the b	edical	•	d									
Вох	ith certi tending or use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	□Ectopic pre					2	23d. Date of deliv	ery Day Year
P.O. E	that the des led by the al	Physician/Med	1 □ Yes 2 No 9 □ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (spe	cify)						
	uires that signed b d be deta		Part II. Other significant conditions co	ntributing to death but no	ot resulting in the i	underlying ca	use giv <i>e</i> n	n in Part I.				_	the cause of death?
Records,	w requir been si should	eted	CNOWILL VIOR	1 rango						24a. Was		, _	opsy findings available
Re	The lay	Completed by								autop		prior to co death? 1 \(\text{Yes}	ompletion of cause of 2 □ No
Vital	Physician: The la this certificate haveral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Other	_		(Check only o			
o	Phy this ald	n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time ar) Injury		Bc. Injury a	4 🗀 (40)		ne 5 ☐ Resid 28d. Describe f		S □Other (Spec y occurred	ify)
Division	Attending Firdeath. ector: After by the funera	catlo	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			М	1 🗆 Y	es 2□i		19f Location (Street an	d Alumbar or Ru	ral Route Number,
Divi	al or At s after c il Direct d in by	Certification:	4 Homicide determined	28ø. Place of Injury - building, etc. (S	pecify)	treet, ractory,	OTICE			City or Tox			al moute wattoer,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		rsician: To the best of miner: On the basis of exa and manner stated.									
-	vithic To th	N.	29b. Signature and tifle of certifier	200		29c.	License	number				e signed (Month	
			30. Name and address of pers n who c	o pl ted cau of tath	(Item 23a) (Type	, Print)	1.00	74 Y		1 0)	• > \	06 12106
	2		Midnet Ru	32. Registrar's	1838	OVE	gyge	TV	412	d Do	ITIK	uce M	3006
3	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 2 7			barte	,						

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of	Maryland		artment rtificate			and M		giene Reg. No	ZUUD.	17385
Dhyaia	, S	1. Decedent's Name (First, Middle, L	ast)							Date of Dea Month	ath Da	y Year	3. Time of Death
Physici /Medi		Lenora G	Galar	ns						May 2	-	2006	8:00 P M
Examir		4a. Facility Name (If not institution, g		iber)		, ,		Location o			4c	. County of Death	
		6422 O'Donnel1						more					N/A
Funeral Director		235-30-4444	Sex 1□M 2☐xF	7, Age (In yrs. I 80	Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birt (Month, Day Sept.	y, Year)	Con	place (State or Foreign intry) t Virginia
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Maryl f sho	ō	Maryland	N/A					Bal	timo	re City			1 ☐ Yes 2 🔁 No
the the	rec	10e. Street and Number				10f. Zip (Code				10g. Cit	izen of What Cou	intry?
3a or	0	6422 O'Donnell	Street					21:	224		Ur	nited Sta	ates
death ms 2	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Decede	ent of Hi			cify Yes or No- Rican, etc.)		14. Race - Amer	
after or Ite	E	1 Never Married 2 Married	Armed For	2 🔽 No		1 Tes, speci 1 ☐ Yes 2		Specify:	, Puerto	nican, etc.)		Black, White	, etc.
ral',	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Da	ites:		10 165 2	A INO	Зреспу.				Specify: Wh:	ite
72 hours after death with the Maryland natural, or Items 23s or 28s-f show deal Examiner mutike natilised at	Completed	15. Decedent's (Specify only highest of	Education rade completed)		(Give	dent's Usual kind of work	done d	lurina most	t of worki	ng	16b. K	ind of Business/Ir	ndustry
od within 72 hours aff giene. er than "natural", or itte Medical Exerci	mpi	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use							
led w tygien her t		11 Years 17. Father's Name (First, Middle, La.	201			Homem	aker		r's Name	(First, Middle,	Maidan	Own Ho	ome
id 2 should be filt th and Mental Hy 27 is marked oth traumatic event	Be								da C:		Maidell	Sumame)	
2 should be and Mental is marked c	2	Roy D. McLaug 19a. Informant's Name/Relationship			10h Mailie	a - Addross	(Street o				City o	or Town, State, Zi	in Codo)
12 st h and 7 is n traun	1	Mr. Joseph D. G		Son)		1 Sunb				undalk,			21222
is 1 and 2 of Health ai Item 27 is		20a, Method of Disposition	atans (20b. P	lace of Dispo	sition (Name	e of	- 1		ate		ocation - City or T	own. State
permit. Pages 1 ar Depertment of Hea Important: If Item any injury or othe		1 Burial 2 Cremation 3		state	emetery, crer				a	E /20/2			
it. Partment		4 Donation 5 Other (Special Signature) neral Service Lice	The said	1/20	11-11	Name and	Addres	e of Eacilit	v	5/30/2		Timoni	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene with the matural, or Items 23a or 28a-f show amportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Ita Mcdical Examinational pages.		I free of	y pr	sttl)	7	Duda- 7922	Rucl Wise	k Fun Ave	eral Du	undalk,	Mar	indalk, yland	Inc. 21222
Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that carry one cause on ea	aused the death ach line	DIA	er the mode	_	RCT	ior)	rest,		Approximate Interval Between Onset and Death
cate be executed by sician and the burial-transit	i Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consequence or as a consequence or a consequence	uence of):	Artion	sey	DI	S EA	SE			Demes
cate be ex obysician a the burial	dica	•	d			-							
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23c. If yes, outcome of pregnancy 1										23d. Date of deliv Month	very Day Year
uires that the rail of the rail of the detache	þ	Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the u	nderlying ca	use give	ın in Part I.			obacco i	_	the cause of death?
sician: The law requires to certificate hes been signe rector, page 2 should be	Completed									24a. Was autop perfo 1 \(\text{Yes} \)	rmed?	prior to co death?	opsy findings available ompletion of cause of
ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	Check only o	ne No		30
	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Ir	npatient 2	ER/Outpatier	nt 3 DO/	A Othe	er: 4 □ Nu	rsing Hor	ne 5 Resid	dence	6 □Other (Speci	ify)
ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		of Injury h, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work	rat (? Yes 2 □ I		28d. Describe h	now ințu	ry occurred	
in Dirt	Certification:	3 Suicide 6 Could not determine	28e. Place	of Injury - At hong, etc. (Specify		reet, factory,	office			28f. Location (S City or Tox			ral Route Number,
Hospital 24 hours a Funeral I	dicai		Physiciam: To the aminer: On the ba and mann	asis of examinat									
To the within 2 To the complet	Me	29b. Signature and title of certifier	1			29c.	License	number			29d. Da	te signed (Month,	, Day, Year)
- > - 0		Alicia ()	1.10	$ \geq $,	1.0	1	DA	060	214	1	5	17/nc	
/		30. Name and address of person wh	o completed ausi	e of death (Me)	23a) (Type,	Print)		UBL			1	O I I O CO	212211
6		ALICIA DORA	18 J	5505	1+00	KIN	SA	20L	Viec.	.) Cal	ec l	e RHT	21224 T. MD.
St	ate	31. Date filed (Manth, Date, Year)	06 / B.R.	egistrar's Signa	ure	Me.		7				1010	
Regist	rar		and the same	200	1	7575							

06-03672 Donte Hudson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

5

			1- For State Registrar		ficate of Dea		ontai i iy	_	eg No. 2 (006 1738	
	Physicia Exami		Decedent's Name (First, Middle, Last)					2. Date of Dear Month May 30, 2		3. Time of Death 0200 hrs	
Juluar	LAGIIII		DONTE J. H 4a Facility Name (if not institution, give street and number	IUDSON_	4b. City	Town, or Locat	ion of Death	May 30, 2	4c. County of I		
			Johns Hopkins		Balt	more			N/A		
	uneral irector			ge (In yrs. last	birthday) If Un Mon		Jnder 24Hrs ours Min.	8. Date of 8in		9 8irthplace (State or oreign	
	rector		216-55-5152 1XM 2F Usual Residence of Decedent	28	Yrs			07/07,	/1977	Country) MARYLAND	
	aû		10a. State 10b. County	10c. City, To	wn or Location				<u></u>	10d. Inside City Limits	
land	f show	ior	MARYLAND N/A	В	ALTIMORE					1 XYes 2 No	
Mary	or 28a- ied at	irec	10e. Street and Number		10f. Z	p Code		10	0g Citizen of What	Country?	
with th	items 23a or 28a-f show any	ra D	14 0 6 GITTINGS AVENUE 11. Marital Status 12. Was Deceden	t Ever in U.S.	13. Was Dece	21239 lent of Hispanic	Origin? (Spe	ecify Yes or No-	U.S.A	American Indian, 8lack,	
death v	or item must b	Funeral Director	1 XXNever Married 2 Married Armed Forces' 1 X Yes 2	? No	If Yes, spec	cify Cuban, Mexi	ican, Puerto I	Rican, etc.)	White, e		
safter	ral", o	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:			2 X No spec				BLACK	
2 hour	"natu I Exan	Completed	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or		a. Decedent's Usua during most of w				16b. Kind of Busin	ness/Industry	
036	r than Iedica	mple	12th grade		COUNSELC	R			COPE	HOMES	
15-0 filed w	And Hygiene "natural", narked other than "natural", event, the Medical Examiner		17. Father's Name (First, Middle, Last)						Maiden Surname)		
212	nd Mental Hygiene is marked other than atic event, the Medical	To Be	MICHAEL HUDSON 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Addres			D TAYI		State, Zip Code)	
M Sho	Ith and n 27 is numati		Theresa Taylor/Mother 1406 Gittings Ave., Balto. Md., 21239								
Baltimore, MD 21215-0036 Dermit. Pages 1 and 2 should he filed within 72 hours after death with the Maryland	nt of Health and N.t. If item 27 is not better traumatic		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from St		ce of Disposition (Na matory or other place		<i>'</i> ,	Date	20c. Location - Ci	ty or Town, State	
time	Department of Important:		4 Donation 5 Other Specify 21 Signature of Fundral Service Licensee	ARB	UTUS MEMO		06-	03-06	BALTIMO	RE, MARYLAND	
Bal	Depar Impo injur		21 Signature of Full et al Septic Grit de lisée			M C BRO W NORTH			FUNERAL	HOME P.A.	
	sician		23a. Part Ener the disease, or complications that caused failure. List only one cause on each line.	the death. Do					est, shock, or heart	Approximate Interval 8 etween Onset and	
	ledical aminer		Immediate Cause (Final disease a Shotgun Wound		and Extremition	es				Death	
and the same			or condition resulting in death) Due to (or as a cons Sequentially list conditions, b.	equence of):						: ×	
		iner	if any, leading to immediate Due to (or as a cons	equence of):							
11 =		Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a cons	equence of):						-	
Xecute	and - transit	SalE	d_						" "=		
760, icate be e	physician and the burial - tra	/Medical	UNPENDED AMENDED IF FEMALE: 23c If yes, outcome and the second of the s	me of preamer	101				Tood Date of de		
Records, P.O. Box 68760, The law requires that the death certificate be execut	ding ph	_ =	23b Was decedent pregnant in the past 12 months?		2 Fetal death	3Ect	topic pregnan	ісу	23d Date of de Month	Day Year	
Box	e attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	t time of death	5 Other (Sp	ecify)					
O. H.	ned by the a		Part II. Other significant conditions contributing to deat	h but not resul	Iting in the underlying	ig cause given in	n Part I.	23e Did to	bacco use contribu	te to the cause of death?	
S, D	n signed l	ed by						1 Yes	2 V No 3	Probably 4 Unknown	
Records, P	has been a 2 should	Completed			_			24a. Was a autops	sy prio	re autopsy findings available r to completion of cause of	
Rec	certificate l	Con						1 Yes		Yes 2 No	
Division of Vital	this certi I director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatie	ent 2 EF	t/Outpatient 3	26 Place of De			Residence 6 (Other	
of \	After th	<u> </u>	27 Manner of Death 28a. Date of Inju	ury 28	b. Time of Injury	28c. Injury at W	Vork? 2	28d. Describe h	now injury occurred	54101	
ion	death rtor: / y the fu	Certification	1 Natural 5 Pending May 29, 2006	3007 23	339 hrs	1 Yes 2	No S	Subject shot	<u> </u>		
Sivis Stor A	ours after death eral Director: filled in by the	rtific	Suicide Could not be		e, farm, street, factor	y, office building		or Town, St	tate)	or Rural Route Number, City	
Tosnit:	4 hour Funera	S Ce	29a. Certifier 1 Cortificing Physicians To the heat of se		death occurred at th	e time, date and				Street, Baltimore, M	
Division of Vital	within 24 hours after death To the Funeral Director: completely filled in by the	ledical	one Medical Examiner: On the basis of examiner stated								
_	5 H 5	Me	29b Signalure and title of centifier		29	C License num	ber			(Month, Day, Year)	
	ا م		(albertelly)			O.C.M.E.			May 30, 2006		
	1)/		 Name and address of person who completed cause of a Laron Locke MD. Assistant Medical Ex. 	,	^{a)} I 11 Penn Stree	t, Baltimore.	MD 2120	1			
		tate		ar's Signatur	-	,					

DHMH 17 Rev 1/2001 OCME 2006

	,	1	For State Registrar	ate of Maryland	•	artment of He tificate of D			ene 2006	17387		
	*		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death		
*:	Physicia		JACOUELINE LAVANI	а намтт.том	J			May	30, 1008	3:21A M		
	/Medic Examin		la. Facility Name (If not institution, give street			4b. City, Town, or	Location of Death		4c. County of Deat	h		
	LXumm		UNION MEMORIAL HO	SPTTAL		BALTIM	ORE					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign		
	Director		217-68-0486	² X F 47	Yrs.	Months Days	Hours Min.		/1958	MD		
	ט		Usual Residence of Decedent							10d. Inside City Limits		
	nylan how		10a. State 10b. County	10c. City,	Town or Lo	cation			1 XYes 2 □ No			
	a-f	Funeral Director	MD	BAL	TIMO	RE						
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?		
	23a	ai	933 E. 41ST ST.			21218			USA			
	dea	ner	A A	Vas Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
စ္	after or It	F		☐Yes 2☐No Yes, Give		1☐ Yes 2☐vNo	Specify:		Specify: R1	LACK		
8	ours	d by	3 Widowed 4 Divorced	ear or Dates:								
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f ehow he Madical Exeminational be modified at	Completed	15. Decedent's Educatio (Specify only highest grade cor	n n <i>pleted)</i>	(Give	dent's Usual Occupa kind of work done of	furing most of work		6b. Kind of Business	Industry		
7	hen hen	ш		College (1-4or 5+)		DO NOT use retired,	/					
2	Hygle Hygle other t		10TH 17. Father's Name (First, Middle, Last)		UNE	MPLOYED	18 Mother's Nam	e (First, Middle, M	laiden Sumame)			
Maryland	d fa b	Be								N.T.		
Ya	should the marked umatic a	၉	GEORGE MOSELEY		405 14-15-				HAMILTO City or Town, State,			
Ja	2 sho		19a. Informant's Name/Relationship (Type, I			•				1		
	1 and 2 Health tem 27 i	,	CELESTINE POWELL,			KATHLAN esition (Name of	the same of the same of		OC. Location - City or	21207		
5	Pages 1 nent of H int: If ite iry or ot	١.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	val from State	metery, crei	matory or other place	θ)					
Baltimore,			4 Donation 5 Other (Specify)	TR								
3al	permit. Departr Importu any Inju		21. Signature of Funeral Service Licensee	11. 7								
-	0 □ F ≈ 0		Maney Z.	Hunter								
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the death. ause on each line.	Do not ent	1	g, such as cardiac	or respiratory arre	ST,	Interval Between		
	Physician		Immediate Cause (Final disease or condition	+ lash lyln	onary	Edema				5 minutes		
	/Medical		resulting in death)	Due to (or as a conseque	ence on:	Λ.			L. HUNTER FRNL. SER BALTIMORE, MD 212. Approximate Interval Between Onset and Death			
	Examiner		Sequentially list conditions, b	End-stage	Kenal	Discuse				10 years		
5.1	₽ #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					15		
40	and trans	Examin	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseque	25.00 of):					10 years		
ő,	be executed sicien and burial-transit			Due to (or as a conseque	51100 017.							
8760	ate the	dicai	d									
9	leath certific attending p	Me	IF FEMALE:	f yes, outcome of pregnan								
Вох	ath co	lan/	23b. Was decedent pregnant	1 Live birth 2 ☐ Fetal o	death 3[Ectopic pregnancy			23d. Date of de Month	Day Year		
	the a	Physician/Me	1 Vac 2 No	4□Pregnant at time of dea 9□Unknown	atn 5L	Other (specify)						
P.0	that the de led by the a detached t		Part II. Other significant conditions contribu	uting to death but not resul	ting in the u	inderlying cause give	en in Part I	23e. Did tob	acco use contribute t	o the cause of death?		
	signe signe	by	Part II. Otto significant conditions control	ating to dout i bat not room	ing in the a	moonying saddo give	or are are a	1 ☐ Ye	. /	robably 4 Dunknown		
Records,	w requii been s should	Completed										
ec	elaw hasb je2st	d d						24a. Was ar autopsy	/ prior to	utopsy findings available completion of cause of		
<u> </u>		မ် မ						perform 1 Tes 2	1 Yes	210110		
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?					th (Check only one	e)			
of V	S .5	P	1 ☐ Yes 2 ☐ No	1 Umpatient 2 LE		nt 3 DOA Oth	4 Unvuising n		nce 6 □Other (Spe	ecify)		
0	ding P		27. Manner of Beath 1 Natural 5 Pending	8a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe ho	w injury occurred			
<u>S</u>	Attending ir death.	ati	2 Accident investigation				Yes 2 □ No					
Division	or Att after d Direct in by t	Certification;	3 Suicide 6 Could not be determined	8e. Place of Injury - At hor building, etc. (Specify)	me, farm, st)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Fi , State)	ural Houte Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral											
	Hosp 4 hou Fune ely fii	ica	(Check only 2 Medical Examiner:	nn: To the best of my know On the basis of examinati								
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	90	9d. Date signed (Mon	th Day Year)		
	with To		250. Signature and title of certifier	1					•			
Į.	^		I work Chan	2 MD			07700	-19	May 30,2			
	5		30. Name and address of person who comp	/	^	A 1	11 .11	DIL.	. MA 31	210		
			Ankit Chand 31. Date filed (Month, Day, Year)	32. Resistrar's Signat		lemorial	Mospital	, Ug ITIMOR	e, MO 21	dig		
	St Regist	ate	JUN 0 2 2006		2	1-1						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 26 (Paryland) 6856 (6-21-06) Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 26, 2006 William may /Medical 4a. Facility Name (If not institution, give street and number)
4200 POTTER Stree 4c. County of Death 4b. City, Town, or Location of Death Examiner VA Boltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Street 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 12M 20 F 216-34-1610 Usual Residence of Decedent Director MAR 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event, the Medical Exemples outst be notified at 1 XYes 2 □ No Director MARYLAND 10e. Street and Number 10f. Zip Code Og. Citizen of What Country? ō USA.

14. Race - American Indian,
Black, White, etc. 622 PPLETON 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SAMUEL 12 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Mental i TONES ZABETH WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIHORE MD. 2

ate 20c. Location - City or Town, State 4200PG nt of Health at: If Itam 27 | ELLEN HIL MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ₩ Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. KING MEMPARK 06-01-06 WOODLANN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2/40 N. Fulton Ave. 21. Signature of Funeral Service Licensee MO 21217 Joseph H. Brown Funeral Home Baltimore Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval 8etween Onset and Death Myocardial Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home—6 Residence 6 Other (Specify) WITE 5 examiner? 1 ☐ Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA After this of funeral direction 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 176786

10

Registrar

State

115 Roesler Rord, Glea Burne.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

\$2. Registrar's Signature

affrey Kaiz

JUN 0 2 2006

31. Date liled (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** May 29. Charles Webster Werbert, Jr. 2006 1:09AMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11☑M 2□F 579-38-5058 75 Yrs Virginia July 26,1930 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Exertities nuest be notified at 1 Yes 2 No Prince George's Clinton Director Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 20735 U.S.A. 8500 Mike Shapiro Drive Apt. 429 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I∭Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1948 Baltimore, Maryland 21215-0036 Specify White ģ 3 ☐ Widowed 4 ☐ Divorced 1968 "neturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygies important: If item 27 is marked other th any injury or other traumatic event, the once. 12 Mechanic Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Webster Herbert, Sr. Daisy Madeline Bradshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Herbert (Wife) 8500 Mike Shapiro Drive Apt. 429 Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June Date. 1\sum_ Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 2006 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Listansee 22. Name and Address of Facility Lee Funeral Home, Inc. seen Stan 6633 Old Alexandria Ferry Road Clinton, MD 20735 Norms moo 257 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Physician /Medical Examiner CARDIOMYD PATNY Esquentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed RONARY Due to (or as a consequence of Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for i Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2**X**XNo 1 ☐ Yes : After this certifica s funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Manpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3885 30/06 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) lons 0 KAMANAN # 307 SURRA?75 1501 32 Registrar's Signat 31. Date filed (Month, Day, Year) State JUN 0 2 2006 Registrar

		1 - State Registrar	State of Maryland		artment of H			ene g. No.2006	17390		
Physi		1. Decedent's Name (First, Middle, Last)	Hanback				2. Date of Death Month May 30,	Day Year	3. Time of Death		
/Med Exam		4a. Facility Name (If not institution, give s Taylor Farm Assi			4b. City, Town, or Bushwo			4c. County of Dea			
Funera Directo		5. Social Security Number 6. Sex 577 28 1252 XX	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 6,	1922 9. Bi	rthplace (State or Foreign country)		
r 28e-f ehow	rector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 Maryland St. Mary's Bushwood 10g. Citizen of What Cour									
ife, INIALY INITION AT A TONO SO. I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Examination in the Initial at	by Funeral Director	21748 Oscar Hayd 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	en Road 12. Was Decedent Ever in U.S Armed Forces? 1	'	2174 Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 25 No	spanic Origin? (S)	pecify Yes or No-	United St 14. Race - Arm Black, Wh Specify:	erican Indian,		
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ar ylarid should be file and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last) Ellis D. Hanba	ck , Sr.			Lill	ian B. Mo	Goinnes			
and 2 sho ealth and n 27 le m			(Daughter)	7012	Bluebird		ace, Hugh	City or Town, State,	MD 20637		
Page nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	m <i>etery cre</i> r lar Hi	sition (Name of natory or other place 11 Cemete	ry June	5, 2006	Suitland,	MD		
permit. Departing	Suc Suc Suc Suc Suc Suc Suc Suc Suc Suc	21. Signature of Fineral Service Liber	AS MOIL	101	Alexandri	a Ferry	Road, Cli		20735		
Ilicate be executed Medica Examine physician and st the burial-transit	al	23a. Papf. Enter the disease, or complished. Shock, or heart failure. List only or Immédiate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). AIZHEIMER Due to (or as a consequence).	upper ence of): S dei ence of): Vunc		g, such as cardiac	or respiratory arre	ist,	Approximate Interval Between Onset and Death Z months		
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II KECOTGS: The law requires cete has been sign page 2 should be	Completed						perform	autopsy prior to completion of cause of death?			
or VICa Physician this certifications at director.	To Be	25. Was case referred to medical examiner? 1		ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	er: 4 🗆 Nursing H	ome 5 Reside	nce 6 X Other (Sp	sted Living ecity) Center		
DIVISION (To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	m e , farm, sti	reet, factory, office		28t. Location (Sti City or Town	reet and Number or F , State)	Rural Route Number,		
To the Hospital or within 24 hours after to the Funeral Dir	Medical (sician: To the best of my knowner: On the basis of examinat and manner stated.								
To the To the Comp	×	29b. Signature and title of certifier Colleen D. 3	Jude, M.D.	Jul	29c. License D2	8544	25 1	MAY 31, 20	nth, Day, Year)		
134	1	30. Name and address of person who or 23511 Holly W	100d Street	Suite	Print) Lea	onard te	wy, M	d. 2065			
200 200 200	State istrar	31. Date filed (Month, Day, Year) JUN 0 2 200	Registrar's Signa	уге	de						

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/illiam Edward H			ate of N	/Jaryland	Depar	tment c	f Health	and Men	ital Hyg	liene		000	(1700
	R	For State eqistrar			Certi	ficate o	f Death		2	Date of Dea	eg No.		3. Time of Death
Physiciar Medical Examin	"	. Decedent's Name (First, Middle								Month May 30, 2	Day	Year	1614 hrs
Medical Examin		William Edward Ja. Facility Name (if not institution					4b. City, To	wn, or Location		,		County of Deat	h
		106 Chatham Place	., 0				Bel Air				Ha	rford	
Funeral	ŧ	. Social Security Number	6 Sex	7. Age	e (In yrs. las	t birthday)	. If Under		_	8 Date of Bi	rth(MM/DI	D/YYYY) 9. Bi Fore	rthplace (State or gn
Director	-1	217-50-2046	1 XM	2_F	58	Y	Months rs.	Days Hours	s Min.	March	21,	1948 °	ountryMaryland
		Jsual Residence of Decedent											10d. Inside City Limits
v any		10a. State 10b. County	-			own or Loca	ation						1 Yes 2 No
Maryland 28a-f show d at once.	টু	Maryland Harfo	rd		Ве	l Air	10f. Zip (Code	-		10g Citize	en of What Co	21
Mary r 28a	Director	10e. Street and Number								Ī			USA
with the Maryland ms 23a or 28a-f sho be notified at once.		106 Chatham Pl 11. Marital Status	ace	Was Decedent	Ever in U.S	. 13. W	Vas Deceder	014 t of Hispanic Ori	igin? (Spec	ofy Yes or N	0- 1		rican Indian, Black,
ath wi	Funeral		arried	Armed Forces?		If	Yes, specify	Cuban, Mexicar	n, Puerto Ri	ican, etc.)		White, etc.	
, B : 5		3 Widowed 4 Div	orced If Ye	23	No	1	Yes 2	X No specify	<i></i>			_{Specify} Whi	
136 thin 72 hours af ne r than "natural ledical Examin	d b	15. Decedent's Education (Spe			npleted)			occupation (Give ing life. DO NOT			16b. Kii	nd of Business	/Industry
5 72 ho un "na	i ge	Elementary/Secondary (0-12)		College (1-4 or	5+)	3	Stock	_			5	uperma:	rket.
within iene er the	Completed	12 17. Father's Name (First, Middle	I noth						er's Name (F	irst, Middle,			
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica				. C.				Marc	arot	Lillia	n Co	leman	
2121; Mental Filmarked c event,	o Be	Howard Nelson 19a Informant's Name/Relations	hip (Type,	Print)		19b. Maili	ing Address	(Street and Nu	imber or Ru	ral Route Nu	imber, City	or Town, Sta	te, Zip Code)
and 2 shou lealth and N tem 27 is n traumatic	-1	Calvin L. Hardy				106	Chatha	m Place	. Bel	Air,	Mary	land 2	1014
Baltimore, MD 21215-0036 oemit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "nijury or other traumatic event, the Medical.	1	20a. Method of Disposition				1000 01 0100	osition (Nam other place)	e of cemetery,		Date	20c. To	ocation - City o	or Town, State
imore Pages 1: ment of H tant: If it		1 Burial 2 X Cremation 4 Donation 5 Other S		Centoval Holli Ol	Hi]	1top	Servio	e Corp	_06-	03-06	TOW	son. M	arvland
Baltimo permit Page Department of Important: injury or ott		21. Sign. uye of Funeral Service	Licensee	1		³²	Name and	Address of acili	T Hom	e. P.Z	A.		
Q § § § E.E.		23a Part Enter the disease, or	Me	cyly_		1	317 Cc	kesbury	Rd.	Abing	rest shor	Mary	and 21009 Approximate Interval
Physician		23a Fart Enter Di disease, or failure. List only one cause	on each li	ne.									Between Onset and Death
/Medical		Immediate Cause (Final disease or condition resulting in death)		erosclerotic			isease co	mplicated by	y Enviror	nmental I	Hypertn	ermia	-
			b.	to (or as a cons	sequence of). 							
	je.	Sequentially list conditions, if any, leading to immediate		to (or as a cons	sequence of):							
	Examine	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	U	to (or as a cons	sequence of	·):							
Industrial Industrial		events resulting in death) Last	d										<u> </u>
e executed	lical	UNPENDED	_ Al	MENDED									
Box 68760, e death certificate be the attending physicied for use as the burned for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in		3c. If yes, outco	me of pregr			3 Ector	pic pregnan	icv.		Date of deliver	ery Day Year
68' certifi nding ise as	ian	past 12 months?		Live birth Pregnant a	nt time of de	_	Fetal death Other (Spe		pic program	,			
30x death	ıysi	1 Yes 2 No 9 Ur		Unknown									(1.110
cords, P.O. Box 68760, aw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit		Part II. Other significant cond	tions co	ntributing to dea	ith but not re	esulting in th	e underlying	cause given in l	Part I.				to the cause of death?
P.O.	d by	Chronic Alcoholism								1			autopsy findings available
rds v requ s been should	lete	i									opsy formed?		o completion of cause of
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tal Records cian: The law requi certificate has been ector, page 2 should	Be Completed	25. Was case referred to medic						26.Place of Deat					
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Division of Vital Records, tall or Attending Physician: The law requiral birector: After this certificate has been selled in by the funeral director, page 2 should bled in by the funeral director, page 2 should be	T: T	27. Manner of Death 1 Natural 5 Po		28a Date of In (Month Day FOUND:	njury (Year)	28b. Time FOUND:	of Injury	28c. Injury at Wo				to hot envi	ronment
IVISION 1 or Attend after death Director:	atic		nding estigation	May 30, 200	06	1547 hrs		, office building,		28f Location	(Street a	nd Number or	Rural Route Number, City
Divisipital or Attours after derail Direct filled in by	Certification:	det	uld not be ermined	(Specify) Y		orrie, raimi, s	street, ractor	, omoo bananig,				ce, Bel Air	
Ospita hours unera		4 Homicide 29a. Certifier		1		ne death o	curred at th	e time, date and			_		
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death Tro the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only 2 Medical Ex	aminer: O	n the basis of ex	camination a	nd/or invest	igation, in m	y opinion, death	occurred at	the time, da	ite and pla	ice, and due to	the cause(s)
To with To com	Mec	296. Signature and title of certi	lier ar	nd manner state	<u> </u>		29	c. License numb	per		29d. l	Date signed (Month, Day, Year)
		1 X Martin	los	U)				O.C.M.E.			May	31, 2006	_
IXI		30. Name an address of person					-		MD 646	24			
61				nt Medical E			enn Stree	t, Baltimore,	MD 2120	JT			
S	tate	31. Date filed (Month, Day, Yea	r)	32. Regist	rar's Signat	ure							

Registrar

JUN 0 2 2006 Research & GRIGINAL

Amend item#20b,perrH,0850_6/5/06 TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** man June 11:00 AW 2006 Kathru /Medical 4b. City Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BÁLTIMORE 15more romwell ursin Date of Birth (Month, Day, Year) 07-29-1919 If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 X X PENNSYLVANIA 86 230-09-7492 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f shov traumatic event, the Medical Exerciner nust be notified a BEL AIR 1 ☐ Yes 2 (XNo MD. HARFORD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "--- any injury or other traumete." ò 21015 U.S.A. 704 CEDAR DAY DRIVE Herns 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XX No If Yes, Give 1 Never Married X2 Married 1 ☐ Yes 2 (XNo Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 12 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CANTWELL KATHRYN MICHAEL S. DILL ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HOFFMAN (HUSBAND) 704 CEDAR DAY DRIVE, BEL AIR, MARYLAND, 21015 JAMES W. 20b. Place of Disposition (Name of commetery, crematory or other place)

ST. JOHN NEWMAN CEMETERY 06-05-2006 CHALFONT, PA. 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 1050 YORK ROAD 21. Signature of Funeral Syrvice Licensee (R. G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) h vTGmice /Medical Examiner Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? ate hes been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Tyes 2.100 1 ☐ Yes 2 ☐ No After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 12 hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury et Work? 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 MNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of contified 2006 m Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 Loch Inglin GAO 31. Dale filed (Month, Day, Year) State JUN 0 2 2006 Registrar

State Registrar ela

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Division

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,

Director with the Maryland filed within 72 hours after death permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o Physician /Medical Examiner the Hospital or Attending Physician: Certification: within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD, PhD May 12, 2006 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Victoria Hsiao, Johns Hopkins Hoppital, 600 North Wolfestreet, Baltimore, Maryland 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 2 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1 PER Phy G856 6/02/Gertificate of Death 2. Date of Death Ronald Henry, Karas Year **Physician** 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2058 Pawlet Drive Crofton Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**√** M 2□ F 61 May 3, 488-48-1907 Director Missouri Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "natural", or items 23a or 28e-f shov If a Medical Experiment sust be notified at 1 √Yes 2 □ No Missouri St. Louis Ellisville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Carmel Woods Drive

11. Marital Status

12. Was Decedent Ever in U.S. Amed Forces? death v 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States
14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. ⋧ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Training Instructor Construction Ith and Mental Hygie 27 is marked other r treumatic event, permit. Pages 1 and 2 should be file Department of Health and Menial Hy Importent: If item 27 is marked oth any jury or other treumatic event pope. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Karas Helen Kotowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Ketcherside - Daughter 124 Hunters Ru
20a Mathod of Disposition (Name of cemetery, crematory or other place) Hunters Run Ct. Eureka, Missouri 63025 position (Name of 20c. Location City of Town, State Jefferson Barracks, * 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 5/31/06 Missouri 21. Slower re of Funeral Salved Licensee 22. Name and Address of Facility Shrader Funeral Home, Inc. M01113 14960 Manchester Road, Ballwin, Missouri 63011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician traeriosclerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events Qualto (or se a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed? Yes 2 🗌 No 1 ☐ Yes 2 ☐ No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner 1 Yes Hospital: Other: After this c funeral dire Certification: To 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 V esidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ROUT ne and address of person who completed cause of death (Item 23a) (Type, Print) ONES, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 0 2 2006 Registrar

			1 - For State Registrar	State of Marylan	-	artment of F			giene	ZUUb	17396
	Physici		Decedent's Name (First, Middle, Last)	JAMES WILL	ъм кт	LGORE		2. Date of Dea Month	Day		3. Time of Death 2:00 A
	/Medio		4a. Facility Name (If not institution, give a	street and number)	AII I	4b. City, Town, o	r Location of Dea		28, 2006 2:0 4c. County of Death CARROLL		
	Funeral Director		5. Social Security Number 6. Security Number 172-40-6068	7. Age (In yrs. 3 M 2 F 56		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v. Year)	Cou	place (State or Foreign intry) ISYLVANIA
	filed within 72 hours after death with the Maryland Hygiene. the then natural; or Itame 23a or 28a-f ehow ont, Ita Medical Examinat ment be notified at	Director	10a. State 10b. County MD CARRO 10e. Street and Number		y, Town or Lo ESTMII	NSTER					10d. Inside City Limits 1 XYes 2 No
	23a or	rai Dir	363 N. COLONIAL	AVE.		10f. Zip Code 2 1 1	57		iog. Citi	zen of What Cou USA	intry?
0000	urs after des al', or itame Exercirer m	by Funerai	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: VIET		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (9 un, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		14. Race - Ameri Black, White Specify: WH	
0-617	within 72 ho ane. then "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give life. L	lent's Usual Occup kind of work done of DO NOT use retired	during most of wo f)			nd of Business/Ir	
=	ould be filed with Mental Hygiene arked other the atic event, If a la	To Be Co	17. Father's Name (First, Middle, Last) ROY	KILGORE	COM	JOCTOR 1	18. Mother's Na	me (First, Middle, YS LEWI	Maiden		
נ ב	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Itame 23a or 28a-f show eny injury or other traumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationship (Ty, EVELYN M. KILGO) 20a. Method of Disposition 152 Burial 2 Cremation 3 R	RE - WIFE	363 I lace of Disposemetery, crem	g Address (Street and No. COLOI sition (Name of paterns of paterns of the paterns	NIAL AV	E., WEST	MIN 20c. Lo	STER,	MD. 21157 own, State
Dair	permit. Po Departme Important eny injury once.		21. Sunaturno Forera dervice License		22	CETERANS Name and Addres 54 E. MA	ss of Facility FL	ETCHER	FUN	ERAL H	•
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	ne death certifi the attending I hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ery Day Year		
,	w requires that the base of the part of th	þ	Part II. Other significant conditions con	se contribute to tl	he cause of death?						
י ופכל	ician: The law re certificate has be ector, page 2 sho	Completed						24a. Was a autops perform	y	prior to co death?	psy findings available mpletion of cause of
	Physician: The this certificate hi al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe		th Check only on		☐Other (Specifi	(v)
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	To the Hospital or Attending I within 24 hours effer death. To the Funaral Director: Affer completely filled in by the funer		3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify)			28f. Location (St City or Town	n, State)		
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	641		30. Name and address of person who con			•			- 21	31,20	
P	Sta	te	HERBERT HENI 31. Date filed (Month, Day, Year)	DERSON, MD 32. Havistrar's Signat		MANCHES	STER RD	., MANCH	EST	ER, MD	21102
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te of Maryland / Department of Health and Menta giene			
Certificate of Death	D- N-	2006	- 1

i.		1- For State Registrar		Certific	cate of	Death				Reg. No	21	006		739
Physicia Medical Exami		Decedent's Name (First, Middle, La JOSEPH FRANK KOR	CZYNSKI, S	R.				ı	Date of De Month May 27,	Day 2006	Year		Time of De	
Hebre.		4a. Facility Name (if not institution, gi 202 Sunset Drive	ve street and number)			b. City, Town, Glen Burn		of Death			County of nne Aru			
Funeral Director		5. Social Security Number 6. S 219–26–3830		e (In yrs last bi	rthday) Yrs	If Under 1 Ye		. Adim	Date of B			Foreign	olace (State	
япу		Usual Residence of Decedent 10a State 10b County	N Z F	10c. City, Tow		11_		-	AUG.	7, 13			Od Inside C	
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the Mary 3a or 28a- otified at		10e. Street and Number 202 SUNSET DRIVE				10f. Zip Code 21060				10g. Citize				
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sho sho	오	19a. Informant's Name/Relationship (* JOSEPH F. KORCZYN		SON 1	.530	Address (Stre	DR., 0	GLEN E	URNIE					
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a Method of Disposition 1 X Burial 2 Cremation 3 4 Donaton 5 Other Specify		ite crema	itory or oth	tion (Name of cler place) MEM.		MAY 3		1		•	wn, State MARY	/LAND
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8760, tificate be ng physici as the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom							23d I	Date of d	elivery		
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Divisi pital or Att ours after de neral Direct filled in by	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Inju	ury - At home, t	arm, street	t, factory, office	building, etc	28f	Location (or Town, \$		Number	or Rural	Route Numb	per, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical (ian: To the best of my r:On the basis of exam and manner stated										ause(s)	
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jà.		30. Name and address of pear who Carol Allan, MD Assista	ompleted cause of deant Medical Exam		Penn S	treet, Baltin	nore, MD	21201						
St Regist	ate rar	31. Date filed (Month Pages) 20	06	's Signadire	A CONTRACTOR OF THE PARTY OF TH									

			1 - State Registrar	State of Ma	aryland		rtment of H			jiene 200	16 17398
	Physici	an	1. Decedent's Name (First, Middle, La Louise Warren Ke	•					2. Date of Dea Month May 2	1h 29 Day 200	3. Time of Death 5:00 A M
1	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)				Location of Death		4c. County of	Death
			Brighton Gardens 5. Social Security Number 6. S		(In yrs. la:	st hirthdayl	Baltimor	'e If Under 24 Hrs.	8. Date of Birth	Baltim	Ore Birthplace (State or Foreign
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036	after or ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Ame <i>r</i> ican Indian, White, etc. White
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yland	should be nd Mental marked o	To B	Charles Walter P						e Louise		
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altimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Qther (Specif	Removal from State	20b. Plac	ce of Dispos netery, crem	ation (Name of atory or other place	θ)	Date	20c. Location - Cit	
Baltil	permit. Pag Department Importent: I eny injury o		21. Signature of Funera Sirver Lice			22.	Name and Addres	s of Facility			ork Road , MD 21204
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.						Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		wic	Can	Liony of	athy			Onset and Death
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28/60,	ficate be executed physician and is the buriel-transit	edical Ex	resulting in death) Last	Due to (or as a	conseque	nce of):					
O. Box 6	death certil a ettending id for use e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 0 0 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at t	2 ☐ Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	É	Part II. Other significant conditions of	ontributing to death bu	t not resulti	ng in the un	derlying cause give	n in Part I.		_	te to the cause of death?
r	The la ate has page 2	Completed							24a. Was ar autops perform 1 Yes 2	v prior	e aulopsy findings available to completion of cause of h? Yes 2 \sum No
VIIC	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Impatien	+ م∏-г	NO. dansions	2□ DOA Othe	arter .	th Check only one		
on or		⊢ 4	27. Manner of Death 1 Salural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	-	VOutpatient 3b. Time of Injury	28c. Injury Work	4 Nursing H	28d. Describe ho	nce 6 Other (5 w injury occurred	Specify)
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home (Specify)	e, farm, stre	et, factory, office		28f. Location (Str. City or Town	eet and Number o. State)	r Rural Route Number,
	n 24 hours n 24 hours ne Funera	edicai (20a Certifier (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner state	examination	odge, death n and/or invi	occurred at the time estigation, in my op	s, dals and placs, inion, death occur	and due to the car red at the time, da	use(s) and manne ite and place, and	i as stated. due to the cause(s)
)	To the To the comp.	ž	29b. Signature and title of certifier	~~~)			29c. License	number	29	d. Date signed (M	lonth, Day, Year)
,	10	1	30. Name and address of person who	completed cause of de	ath (Item-2:	3a) (Type, P	rint) C	ريره	/	V(/19 3	0 2006
	10		30. Name and address of person who APAON CHAN (#5) 31. Date filed (Month, Day, Year)					transce	no 2	1204	
	Sta Registra		JUIN 0 2 200	Registral	s signatur	Spe	the?				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10c 17 per fh 9856 6-2-06 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month ee 8:16PM 31 Hervie Ho NA 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITS/ Johns Baltimore Cit Hapkins The 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 8-28-1914 Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Yrs 215-24-2428 VA Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore ¥ Yes 2 No MD 831 N. LINWOOD AVENUE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 831 LINWOOD AVENUE 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXVo Specify Specify. 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 DOMESTIC HOUSEWORK 17. Father's Name (First, Middle, Last)

BOOKER VENEBLE 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES E. LEE/SON 1624 NORTHBOURNE RD. BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEM PARK 6/05/2006 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Signature of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 me 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death tmmediate Cause (Final disease or condition resulting in death) Due to or as a consequence of): 30 minutes 12 FOURS 3 ventrialer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tachin Due to (or as a consequence of): Hypovolemia Due to (or as a consequence of) 5 days IN JUSTION 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetet death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 ANo 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be

/Medical Examiner certificate be executed Box (P.O. Records, Division of Vital Physicien: or Attending

Physician

/Medical

Examiner

Director

Funeral

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the Maryland

id 2 should be filed within 72 hours after death with the Marylar this and Mental Hygiene. 87 is marked other than "naturel; or iteme 23s or 28s-f ehow traumatic event, the Medical Exaction may be notified as

s 1 and 2 of Health item 27 i

permit. Pages 1
Department of H
Important: if ite
any injury or ott

Physician

Baltimore, Maryland 21215-0036

Examine as the burial-transit ettending physicien and for use as the burial-trar Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown ed by the e page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed certificate After this certification funeral director, i Be 25. Was case referred to medical မှ 1 ☐ Yes 2 No 27. Manner of Death Certification: 1 Natural To the numbers ofter death.

Within 24 hours efter death.

To the Funeral Director: Aft 2 ☐ Accident 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the date and place, and in anner at etated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) les -000 31 2006 Medical Doctor MOM

State Registrar

Enyi Nuaneri

31. Date filed (Morth, 1944, Me

DHMH 17 Rev 1/2001

Hospital

600 North wolfe

Street

2128

30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)

The

2006

Johns

Hopkins

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** LEVIN 30th 11:02 AM MAY 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE LEVINDALE HEBREW HOME 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (MONTH / 05 / 1913 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🛛 F 93 Yrs. 216-05-1138 Director Usuaf Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic svent, the World. Examiner must be notified at 1 X Yes 2 No BALTIMORE N/A Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2434 W. BELVEDERE AVENUE 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND ADMINISTRATIVE ASSISTANT i. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 Is marked other th jury or other treumatic event, Ill 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be SARAH BERLIN SIRULNIK **JOSEPH** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 RUTH EAGER COURT - BALTIMORE, MD 21208 ALAN CARMEL / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. BETH JACOB CEMETERY 06/01/2006 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY DISEASE 6415 disease or condition resulting in death) ARTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 3 Probably 4 □Unknown COPD, HIN peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ₺ No certificate 2 No 1 ☐ Yes or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 \(\text{Yes} \) 2 \(\text{No} \) 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D054739 30th mo MAY 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland Avenue 2434 W. Belvedere 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 0 2 Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 4c per DVR G856,06/02/06dhb./DR

Amend Item 21 per FH,6856,06/01/06dhb

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician KANDOLPH 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs BALTIMORG MILFORD MAYOR Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**∑**M 2□ F 02/19/1917 Yrs. MD 89 Director 213-36-5112 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow traumatic event, the Medical Examiner rotal be notified at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Iteme 23s or USA 21215 3120 Tioga Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Schools Educator 12 5± 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hight 11 (18 marked off Be Reid Edith David Myers 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Cedardale Rd.,Baltimore, MD 21215 (son) Louis Myers injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ Removaf from State 4 □ Donation 5 □ Other (Specify) Department or Important: If eny injury or once. 05/15/2006 Baltimore, MD Arbutus 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Vaughn C. Greene Funeral Service 21229
5151 Baltimore National Pike, Baltimore, MD
hter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Vaughn C. Greene per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLON **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 1 Natural 28b. Time of After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the after deatl 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b/Signature and title of certifier mplesed cause of death (Item 23a) (Type, Print) Mai mD 25 32. Registrar's Signature 31. Day Gled (Month Day Xear) State Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Physici		1. Decedent's Name (First, Middle, Last) Trene McDowell 2. Date of Death Month Month Day Year 4:50 PM
	/Medic Examin		4a. Facility Name (It not institution, give street and number) Ab. City, Town, or Location of Death Parinar Health of Cotinsville Catonsville Battimure
	Funeral Director		5. Social Security Number 6. Sex 1 - 212 - 28 - 3752 1 - M 254 7. Age (In yrs. last birthday) 85 - Yrs. 1 - M 254 1 - M 255 1 - M 255 1 - M 255 264 27. Age (In yrs. last birthday) 27. Age (In yrs. last birthday) 37. Age (In yrs. last birthday) 48. Date of Birth 26. Sex 27. Age (In yrs. last birthday) 38. Date of Birth 26. County) 39. Birthplace (State or Foreign County) 264 264 265 264 265 265 266 27. Age (In yrs. last birthday) 27. Age (In yrs. last birthday) 285 287 287 288 288 288 288 288
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	s 1 and 2 should of Health and Men item 27 is merke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Queens gete Lot, Beltimore MD 21229
Baltimore,	t. Pager rtment o rtant: If njury or		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cameter), crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place) 20c. Location - City or Town, State Competer, crematory or other place)
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	Enysician /Medical		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death disease or condition resulting in death) a
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8760,	icate be executed physician and s the burial-transit	licai Examiner	cause. Enter Underlying Cause this area or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
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)			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta	to	31. Date filed (Month, Day, Year) 22. Registrar's Signature
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		•	For State Registrer		•		nd / Depa		t of H	ealth a		ental Hy		006	5 17403
			Decedent's Name (First, Michael Control of the	idle, Last)				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				2. Date of De.	ath		3. Time of Death
	Physicia		Dorothy A. Mc	Colga	n							Month May	20,	Year 200	1.4
	/Medic Examin		4a. Facility Name (If not institut	ion, give st	reet and num	n <i>ber)</i>		4b. City,	Town, or	Location of	of Death			ounty of De	
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	Funeral Director		5. Social Security Number 221–12–7500	6. Sex	M 2⊠F	7. Age (In yrs 82	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Sept.	h y, Year) 15 , 19	9. Bi	irthplace (State or Foreign Country) elaware
	and *	}	Usual Residence of Decedent 10a. State 10b. Cour	nty	_	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
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Maryland 21215-0036	ath of the	Be C	17. Father's Name (First, Midd	le, Last)						18. Mothe	er's Name	(First, Middle,	Maiden S	umam <i>e)</i>	
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Baltimore,	Pages 1 a nent of Hea ent: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic	n 3.⊠2Re	moval from	State A1	Place of Dispo cemetery, crei 1 Saint	natory or o	ther plac	e)]	May 200	24,			or Town, State
ţ	t. Pa ntmen rtent: njury		`4 □Donation 5 □Other		16	1.11						0	MTTM	ingto	n, DE
Bal	permit. Pages Department of I Importent: If it any injury or o once.		21. Signature of Fungral Servi	1/4	Hla		B. 4	arran 95 Go	co &	Sons	e Hw	v. Ses	zerna.	Park Park,	Funeral Home MD 21146
			23a. Part1. Enter the disease shock, or heart failure. L	or complic ist only one	ations that co	aused the dea ach line.	ath. Do not ent	er the mod	le of dyin	g, such as	cardiac d	or respiratory a	rrest,	·	Approximate Interval Between Onset and Death
	Physician	2 II	Immediate Cause (Final disease or condition resulting in death)	_ a.	URG	DSCF	SIS								SDAYS.
н	/Medical Examiner		resulting in death)		Due to (or as a conse	quence of):								
н		<u>.</u>	Sequentially list conditions,	b.		or as a consu	quenda off:								-
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68	ng ph as th	Med	IF FEMALE:										1		I
Вох	th ce tendii or use	an/N	23b. Was decedent pregnant in the past 12 months?	23		come of pregri	tal death 3	Ectopic pr					23	d. Date of d	elivery Day Year
Ö.	the at	Physiclan/Med	1 ☐ Yes 2 🔁 No 9 ☐ Unknown		4∐Pregn 9☐Unkno	ant at time of own	death 5	Other (sp	ecify)						
P.0	that the de ned by the detached		Part II. Other significant cond	litions cont	ributing to de	eath but not re	sulting in the u	nderlying o	ause give	en in Part I			obacco use	contribute	to the cause of death?
of Vital Records,	uires l signe	Completed by	AXTERIOS	cie	ret le	CENR	Diov	15 CU	GR	DUSC	S15t	10	res 27	No 3□ E	Probably 4 Unknown
202	w requir been si should I	ete	TYPE 7	DINS	GIB							24a. Was	an	24b. Were a	autopsy findings available
Re	he lav e has age 2	Ę.				,							rmed?	death?	
tal	icien: The certificate ha		25. Was case referred to med	ical				- 10		26. Place	of Death	1 Yes	2 /25 No	1 □ Ye	es 2 No
<u>></u>	ysicie is cer direct	To Be	examiner? 1 ☐ Yes 2 2 XNo	Н	ospital:	npatient 2[☐ ER/Outpatier	nt 3 🗆 DC	OA Othe	00		me 5 ☐ Resid		Other (Sp	pecify)
0	ig Ph ter th		27. Manner of Death Natural 5 ☐ Per	dina	28a. Date (of Injury th, Day Year)	28b. Time o	f 2	28c. Injun	at </td <td></td> <td>28d. Describe</td> <td>now injury</td> <td>occurred</td> <td></td>		28d. Describe	now injury	occurred	
joi	anding I sath. or: After he funer	atic	2 Accident inve	estigation				М		Yes 2 🗆	No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Cot 4 ☐ Homicide det	ald not be ermined	28e. Place buildi	of Injury - At I ng, etc. (Spec	home, farm, sti cify)	eet, factory	y, office			28f. Location (S City or To		Number or F	Rural Route Number,
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L) ZH	becu	-6/2	- N)			177			MAY	20,	,2006
	3		30. Name and address of pers		npleted caus	se of death (Ite	эт 23a) (Туре. 802 (Print) 211 C	HUB	Rh	7	MAJAD	BUF	A M	D 21122
Ų-	Sta Regist		31, Date filed (Month, Day, Ye		32 R	tegistrar's Sign	nature	st.	7.7.1						

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		-4(Registrar 1. Decedent's Name (First, Middle, Last)	AKA Maria 11		tificati			000	2. Date of De	Reg. No	<u>, 00</u>	U	2 Too of Dooth
	Physic		Maria Lucila Me		ACTIVE DE	1 14120	CODE	elinei	gar	Month 5	28	y Ye	ear	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	f Death	5		County of I	-	11.011
1			24:39 Henslowe I	rive		Pot	om					conto		eru
100	Funeral		5. Social Security Number 6. Sex	IM ONE	last birthday)	If Under Months	1 Year Days	ff Under 2 Hours	24 Hrs. 8	B. Date of Birt (Month, Da	th v. Year	9.		ce (State or Foreign
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	or 28	Funeral Director	10e. Street and Number			10f. Zip	Code				-	izen of Wha	t Country	/?
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	tams Itams	une	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in L Armed Forces?	J.S. 13. W	Vas Deced Yes, spec	lent of His only Cubar	spanic Orig n, Mexican,	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		14. Race - / Black, V	Americar Vhite, etc	
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anc		Be	17. Father's Name (First, Middle, Last) Carlos Del Risco D	0/10/16						First, Middle,			11	1
Maryland	d 2 should th and Men ?7 is marks traumatic	70	19a. Informant's Name/Relationship (Ty)		19b Mailing	n Address				CIELA R			11a	rreal
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Baltimore	Pages ment of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State A a	esaloen	Ke Cr	ement	tory 6	-1-20	200	Be	Itsvil	le r	ND
alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22.	Name and	d Address	of Facility	Rap	PFUNE	ena	C+Cr	ema	ation
	205 2 9			POIS	93	3Gir	st A	we,5		Spring		1020	710	Services
			23a. Part1. Enfer the disease, or complications, or heart failure. List only on	cations that caused the dear e cause on each fine.	th. Do not ente	r the mode	e of dying	, such as ca	ardiac or r	espiratory an	rest,		l lr	pproximate iterval Between
	Physician /Medical		tmmediafe Cause (Final disease or condition resulting in death)	NonHodgkins		ma								nset and Death 8 yrs
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	requires that the de een signed by the a nould be detached f	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	derlying ca	luse giver	in Part I.		23e. Did to	bacco u	ise contribute	e to the	cause of death?
Records,	w require been sig should b	ted	Brain metastasis					,		1 🗆 Y	es 2	XN0 3□	Probabl	y 4 Unknown
ecc	aw 2 st	Completed								24a. Was a		24b. Were	autopsy	findings available letion of cause of
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Division of Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	ospital:						Check only on				
of	Phys r this ral dir	To.	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of fnjury	ER/Outpatient 28b. Time of		1	4 🗀 Nurs		5 Reside			pecify)	
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Ö	s after s Direct ed in by	Certification:	4 Homicide	building, etc. (Specif	y)					City or Towi	n, State,)		
	To the Hospital or Attending Physician: The within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier Certifying Phys	ician: To the best of my know. On the basis of examina	wiedge, death o	occurred a	t the time	, date and	place, and	due to the ca	ause(s)	and manner	as state	d.
	the hin 24 the f	Medi		and manner stated.					occurred					
	To wit		29b. Signature and hills of certifier			1	License					e signed (Ma	onth, Day	r, Year)
	10	Ì	30. Name and address of person who con	nolated cause of death /+	222) /		1140			5)/30	106		
	(0		Peter Shields 38	npleted cause of death (ften	Pd. N.	W. R	m. 15	in Wo	ashir	raton,	D.C.	200	57	7
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture .			0	(17	J. 1	_,_			
12.11	Registr	ar	JUN 0 2, 2006	Harrie . 1	X dog	12)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ahan 201 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner more If Under 1 Year If Under 24 Hrs. 7. Age (lovyrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Maryland Director 212-23-5749 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 1 Yes 2 No Completed by Funeral Director Havre de Grace Harford 10e. Street and Number 10g. Citizen of What Country? **USA** 21078 3807 Rider Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) High School 12th Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kevin S. Mahan, Sr. Melena Hamm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Earlton Rd., Havre de Grace, MD 21078 Rodney Hamm- Grand ather 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/31/06 Havre de Grace, MD Rock Run Cemetery 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. DVI D 123 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Qualto for as a consecuence of Examiner the attending physicien and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2√No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 1 Yes 2□No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred NZ Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) Street 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State 2006 Registrar

Amend item 20b per fh 9856 6-2-06 yt State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** BERTELLE 2006 11:30A Ε. MURPHY MAY 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 216 BALTIMORE & ANNAPOLIS BLVD. ANNE ARUNDEL SEVERNA PARK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F Director 80 JULY 9, SC 218-22-1246 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mantal Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Madical Examinar must be notified at 1XXYes 2 □ No Directo ANNE ARUNDEL MD SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 BALTIMORE & ANNAPOLIS BLVD. 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ADAM WALKER LUCILLE HOLIDAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 216 BALTIMORE & ANNAPOLIS BLVD. SEVERNA PARK, MD HENRY L. MURPHY/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of I
Important: If Ite
ony Injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MEADOW RIDGE CEM. JUNE 5, 2006 ELKRIDGE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. BALTIMORE, MD 21217 1701-31 LAURENS ST. 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATH **Physician** HEMIC /Medical Due to (or as a consequence of): Examiner D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHROWIC REWAL FAILV Q 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records, P.O. Box 68760 this certificate has To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

> State Registrar

DHMH 17 Rev 1/2001

Certification:

Medical

31. Date filed (Month, Day, Year)

5 Pending

investigation 6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Pint)

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

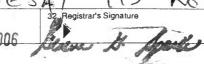
one)

4 Homicide

(Check only

29b. Signature and title of certifier

ARVIND



28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland		irtment of H			ne No.2006	17408
	Physici	***	1. Decedent's Name (First, Middle, Last) Flor	24				2. Date of Death Month May 25,	Day Year 2006	3. Time of Death 3:50AM
	/Medic Examin		4a. Facility Name (If not institution, give s Southern Maryland			Clint			4c. County of Death Prince Ge	eorge¹s
	Funeral Director		101-10-3391	7. Age (In yrs. las M 214	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 21	9. Birth Con , 1922	place (State or Foreign Intry) A
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or items 23e or 28e-f ehow amy injury or other treumatic event, it a Medical Examinat must be notified at 2006.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge 10e. Street and Number 5004 Colonial Dri 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify)) 17. Father's Name (First, Middle, Last) Walter R. All 19a. Informant's Name/Relationship (Ty Billie Smith (Dau 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Bart (Specify)	Ve 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: cation College (1-4or 5+) En pe, Print) ghter) 20b. Place	13. V 16a. Decece (Give life. L Home 19b. Mailin 8217 See of Dispo setery, cred	prings 10f. Zip Code 20748 Vas Decedent of Hi Yes, specify Cubai Yes 24 No Ient's Usual Occupe kind of work done a DO NOT use retired, emaker Ig Address (Street a Hammond sition (Name of natory or other place	spanic Origin? (Spen, Mexican, Puerto Specify: ation furing most of works 18. Mother's Name Georgiand Number or Rura Branch Walley 1 Cem 200	ecify Yes or No-Rican, etc.) Ing 16t 16t 16t 16t 16t 16t 16t 16	Home den Sumame) . hen ity or Town, State, Z , Maryland c. Location - City or	ican Indian, etc. nite ndustry ip Code) 1 20723 Town, State
	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death.	Do not enterince of):	633 Old A ar the mode of dying	lexandria	Ferry Ro	Home, Inc	Approximate Interval Between Onset and Death
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours effer death. To the Funsrs! Director: After this certificate hes been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown Part II. Other significant conditions con	3c. If yes, outcome of pregnanc 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3 th 5 th	Ectopic pregnancy Other (specify)	en in Part I.			Day Year
Division of Vital Records,	anding Physician: The lavath. Jath. or: After this certificete hes he funeral director, page 2	ation: To Be Completed	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 8b. Time of Injury	28c. Injun World	9r. 4 ☐ Nursing Ho	autopsy performed 1 Yes 2 X	d? death? 1 \(\text{Yes} \)	ompletion of cause of 2□ No
Divis	To the Hospital or within 24 hours effe to the Funstal Director completely filled in	Medical Certification;		28e. Place of Injury - At hom building, etc. (Specify) sician: To the best of my knowl ner: On the basis of examination and manner stated. ompleted cause of death (Item 2) 32. Registrar's Signatu	edge, death in and/or in and/or in 23a) (Type,	n occurred at the time vestigation, in my operation of the company	pinion, death occur	and due to the caus	se(s) and manner as	stated. to the cause(s)
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			For	State of Maryland			Mental Hygie	ene no c	171.00
			For State Registrar 1. Decedent's Name (First, Middle, Last,		Certifica	ate of Death	Reg	J. No. C U U U	3. Time of Death
	Physici /Medic		Gloria	Morr			May &	29 2006	5.30 A M
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	Funeral Director		5. Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Second Security Number 6. Second Secon	7. Age (In yrs. la	Yrs. If Unc	der 1 Year if Under 24 Hrs s Days Hours Min.		9. Birthp (ear) 1944	place (State or Foreign
	Maryland -f ehow liad al	tor	10a. State 10b. County	10c. City,	Town or Location Balth	rone		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	I Director	10e. Street and Number 1513 N. Myrt	D 12	10f. :	Zip Code 21217	100	J. Citizen of What Cour	ntry?
36	72 hours after death with the Maryland naturel', or Iteme 23e or 28e-f ehow Geal Exactination notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: AFM	etc.
215-0036	C 2	Completed b	15. Decedent's Edu (Specify only highest grad		16a. Decedent's U (Give kind of life. DO NOT	sual Occupation work done during most of wo use retired)	rking	Am 4	eyeon
2	filed within I Hygiene.	e Con	17. Father's Name (First, Middle, Last)		140	nemater 18. Molher's Na	me (First, Middle, Ma	aiden Sumame)	13
Maryland	thould be id Mental marked c matic ev	To B	John Henry	Porter		<u></u>	ouise	Porter	
_	h ar h ar 7 le trau		Patricia V. Mo	mis Duyliten	3836	oss (Street and Number or Ri The Alam ed	1 1	AMONQ WYO	
Baltimore	Pages 1 and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	ace of Disposition (Numetery, crematory of 4-2 cm Ce	r other place)	Date 20	Dc. Location - City or To	own, State
Balti	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Licens			and Address of Facility and P - (105	e Fonen	al Service in	e. P. A.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ications that caused the death.	Do not enter the m	node of dying, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	CLESOTION OF THE PROPERTY OF T	12	lasecher o	11. Sease	years
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I Records,		Completed					24a. Was an autopsy performs	prior to cor death?	psy findings available mpletion of cause of 2000 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			ath Check only one		
of	Phys ral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 E	ER/Oulpatient 3 28b. Time of Injury	DOA Other: 4 Nursing H	28d. Describe how	ce 6 Other (Specify injury occurred	y)
Division	deat deat ctor: / the	Certification:	2 Accident investigation 3 Suicide Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fact	1 ☐ Yes 2 ☐ No ory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number.
۵	To the Hospital or Attanwithin 24 hours efter deatl To the Funeral Director:	edical Cer	(Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati	viedge, death occurr on and/or investigati	ed at the time, date and place on, in my opinion, death occi	e, and due to the cau	se(s) and manner as st	tated.
	To the To the complet	Med	29b. Signature and title of certifler	and manner stated.		29c. License number	- 3 -	Date signed (Month, I	Dey, Year)
			30. Name and address of person who co	Macen in Market Mark (Item)		D 1550		lay 31	2006
	3		AMDTUH A 31. Date filed (Month, Day, Year)	LASON		Dolphin s	st, Balt.	c, MD a	1217
4	Sta Registi	0.7	IIIN 0 2 2006	az. Registrar's Signar	HOUNEY				

			For State Registrar	State of	Maryla		artment of F <i>rtificate of</i>		Mental Hy	giene	006	17410
	Physici		Decedent's Name (First, Midd	John E.	McMun	ctagh			2. Date of De Month	Day	Year 006	3. Time of Death
F	/Medio Examir		4a. Facility Name (If not institution			Lagii	4b. City, Town, o	or Location of Dea			Inty of Death	8:29 A M
	Exami		Subur	ban Hospit	a 1			Bethesda	9		•	gomerv
	Funeral		5. Social Security Number	6. Sex 7		s. last birthday)	If Under 1 Year	If Under 24 Hrs	s. 8. Date of Bir	th (nplace (State or Foreign
	Director		393-14-4928	1 M 2 □ F	8.7	Yrs.	Months Days	Hours Mir		1, 1918		Canada
	p ,		Usual Residence of Decedent 10a. State 10b. County		10- 0	V. T.						
	aryla ehov	<u>_</u>	10a. State 10b. County	,	10c. C	City, Town or Lo	cation					10d. Inside City Limits
	8a-f	ctc		ntgomery				h Bethe	sda			1 ☐ Yes 2 💢 No
	vith ti	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	untry?
	death with the Maryland wme 23a or 28a-f ehow	ral		venor Plac				20852				l_States
	item item	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Mai	12. Was Deced	es?	0.8.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No nto Rican, etc.))- 14. F	Race - Amer Black, White	
8	irs af	by F	3 Widowed 4 □ Divorce	If Yes Give			1□Yes 2ሺ No	Specify:		Spe	cify:	
ŏ	within 72 hours after ene. than "naturel", or ite ne Madical Examina	Completed by Funeral		nt's Education	es: WW	16a. Deced	dent's Usual Occup	ation		16b. Kind of	Business/I	White modustry
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B	be filed tal Hygid d other	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	Maiden Sum		
<u>Na</u>	should to	2		John McMur	tagh				Saral	n Harbi	inson	
Maryland 21215-0036	and and is ma		19a. Informant's Name/Relations	ship (Type, Print)	7.1	19b. Mailir	g Address (Street	and Number or A	ural Route Numb	er, City or Tov	vn, State, Zi	ip Code)
	and seelth		Kevin T. McMu	rtagh/Son		45	Thunder	Ridge La	ane, Acwo	orth, (Georgi	a 30101
ore	Pages 1 ent of H int: if ite		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from St	1	cemetery, crer	sition (Name of natory or other place	·	Date	20c. Locatio	n - City or T	own, State
Ē	Pag Imeni Iant:		4 Donation 5 Dother (5			Nationa	ington I Cemete	ry 19,	^{une} 2006	Arli	ngton	, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. important: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show eny highry or other traumatic event, the Mardical Examinar mant be nutified at once.		21. Signature of Funeral Service	Licensee	мос)335 Be	Name and Addre ethesda-C ethesda,	ss of Facility Ro Chevy Cha Maryland	bert A.	Pumphr	ey Fu Wisco	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cau		ith. Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory a	rrest.		Approximate Interval Between
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	/Medical		resulting in death)		as a conse		Lat TIDII	TIACION	-			3 Minutes
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387	phys s the	edicai		d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn	ancy				224 (Data of data	
ŭ	death cert ettending of for use	ciar	in the past 12 months?	1 ☐ Live birt	h 2 ☐ Feta	al death 3 🗌	Ectopic pregnancy Other (specify)				Date of deliv Month	Day Year
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ري ت	s that	by P	Part II. Other significant conditi	ons contributing to deal	th but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use co	ontribute to t	he cause of death?
Vital Records,	w requires been sign should be	ed to							101	res 2∏No	3 🔲 Prol	bably 4 Unknown
ပ္သ	s bee	plet							24a. Was	an 24t	o. Were auto	opsy findings available
č	The lay	Completed								ngd?	prior to co death?	ompletion of cause of
ā	Physicien: The la r this certificate have ral director, page 2	O	25. Was case referred to medica	ıt				26. Place of De	1 ☐ Yes ath (Check only o	28 No	1 🗆 Yes	2 No
<u>-</u>	nysic nis ce direc	10 B	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 11 Inp	atient 2	ER/Outpatient	3 □ DOA Othe	er: 4 🗆 Nursing H	lome 5 ☐ Resid	dence 6 □0	ther (Specia	fv)
0	Attending Physicien: r death. ector: After this certific: by the funeral director;		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe I			,,
Division of	uttendii death. ctor: A y the fu	atio	2 Accident investi	gation				Yes 2 □ No				
_	- 0 -	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place of	Injury - At h , etc. <i>(Speci</i>	nome, farm, stre fy)	et, factory, office		28f. Location (S City or Tox	Street and Num n, State)	nber or Rura	al Route Number.
	urs a											
	To the Hospital o within 24 hours aft To the Funeref Di completely filled in	Medical	29a. Certifier (Check only one) U∑ Certifyir 2 Medical	ng Physician: To the be Examiner: On the base and manner	s of examina	owledge, death ation and/or inv	occurred at the time estigation, in my of	ne, date and place pinion, death occu	a, and due to the ourred at the time.	cause(s) and r date and place	nanner as s a, and due to	stated. o the cause(s)
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•	.0.1		- all	1/600	J W	IV		Do7147		Ma	y 30,	2006
1	121		30. Name and address of person									
	V		Allen C. Nimetz 31. Date filed (Month, Day, Year)) Wisc istrar's Sign:		venue Ch	evy Chas	e, Maryl	and 2	0815	
	Sta Registra		JUN 0 2		West Sign	y doe	Les .					

McMustagh, John E

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State of M	faryland / Department	of Health and	Mental H	ygiene 2	000

			1 - For State Registrar	State of Ma			cate of l		_	giene Reg. No		1 / 4 1
	Physic	ian	Decedent's Name (First, Middle, Last		DD NIC	71 m = N7	CALD		2. Date of De Month	Da	y Year	3. Time of Death
	/Medi			BONNIE I	JEE NIG				JUNE	1,	2006	2:15 P ^M
¥	Examir	ner	4a. Facility Name (If not institution, give CARROLL HOSPIT		7.15			Location of Death	1		County of Death	
			5. Social Security Number 6. Se		SK e (In yrs. last birth		ESTMII	NSTER If Under 24 Hrs.	8. Date of Bir		CARROLL	
	Funeral Director			M 2₫F			nths Days	Hours Min.	10/9/1	ıy, Year)	PENN	olace (State or Foreign otry) SYLVANIA
	land bw		10a. State 10b. County		10c. City, Town	or Location	1	-			1	0d. Inside City Limits
	Mary 	ξ	MD CARROL	T.	WESTM	TNST	ਰਾਜ					1 ☐ Yes 2 🕱 No
	r 28a	rec	10e. Street and Number		1120111		f. Zip Code			10g. Cit	izen of What Cour	ntry?
	23a o	Funeral Director	705 LONGVIEW A	VE.			211	57		US	SA	
	dea	nec	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was D	Decedent of Hi	spanic Origin? (Si n, Mexican, Puert	pecify Yes or No		14. Race - Americ	
200	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other then "netural", or iteme 23a or 28a-f ehow other traumatic event. The Medical Examinar must be notified at	5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	1 □ Yes 2 📉 N If Yes, Give Year or Dates:	10		es 2X No		Triodii, etc.)		Specify: WHI	
ה ה	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. [Decedent's Give kind o	Usual Occupa	ation furing most of work	kina	16b. K	ind of Business/Inc	dustry
7	Athin Page 1	ם	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NO	OT use retired,)	g			
V	lled v tygie her ti		1 2 17. Father's Name (First, Middle, Last)			OWNE	:R				UTY SAL	ON
2	ntal H	Be		LES WIL	TAM CT	ODD.		18. Mother's Nam			,	
<u></u>	hould id Men marke matic	2	19a. Informant's Name/Relationship (Ty				drace (Stract a				ROBERTS or Town, State, Zip	
2	id 2 should and 27 ie m		JASON L. NIGHTI									
בֿ	Hea Hea Hea Hea Hea Other		20a Method of Disposition		20h Place of F	Disposition	(Nama of		Data	20-1-	Cit T.	- 0: :
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<u> </u>	permit. Pages Department of I important: if ite eny injury or of		21. Signature of Funeral Service Licens	9/1	1	22. Nam	ne and Addres	s of Facility FL	ETCHER	FUN	VERAL HO	OME
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,	DE IS	nlne	cause. Enter Underlying Cause (Disease or injury	Ohai	L L L): 	bt . h.	· · · C · ·	4.			\$1
	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	20 0	19.000	Tr syn	ovomi			
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5	tificate ng physi as the l	fedical										
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	e dea he att	Physician/A	in the past 12 months? 1 Yes 2 No	4☐Pregnant at t			r (specity)				Month	Day Year
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	n: Th icate r, pag								1 ☐ Yes	med? 2 ⊠No	death?	2□ No
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5	ding I th. After funer	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Inju		28c. Injury Work	es 2 No	200. Describe in	OW injury	, occurred	
2	Attender death rector:	lflca	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, larm	, street, fa			28f. Location (S	treet and	d Number or Rural	Route Number
5	safte safte od in t	Certification;	4 Homicide	building, etc.	(Specify)				City or Tow	n, <i>State)</i>		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical (29a. Certifier 1 Certifying Phys (Check only one)	er: On the basis of	examination and/	death occur or investiga	red at the time	e, date and place, nion, death occur	and due to the o	ause(s)	and manner as sta place, and due to	ated. the cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stat	ou.		29c. License				signed (Month, D	
	- ≯ ⊢ ĕ		Hay H. Myur	MD								• • • •
	/		30. Name and address of person who co		ath (Item 23a) (To	ne Print					11/200	6
	b		HTAY IT MYINT.	MD 2α	Memor	21AL	AVE.	WESTMII	USTER.	MD	21157	
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DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of Ma	aryland				lealth a D <i>eath</i>	and M	-	giene Reg. No	21116	References to the second	13
		1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	y Yea	3. Time	of Death
nysiciar Medica	_	JOSEPH R. PC	SEY SR.							MAY	14	2006		a l
xamine		a. Facility Neme (If not institution, given	re street and number)			4b. City,	Town, or	Location of	of Death		4c.	County of De	ath	
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neral	- 1		Sex 7.Ag 1x∑M 2□F	ie (In yrs. las		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da	ıy, Year)	9. B	irthplace (State Country)	or Forei
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22		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limi
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9	5	1801 WYE CLIFFE COURT					122				-	.S.A.	Southly.	
DINE .	- T	11. Marital Status	12. Was Decedent	Ever in U.S.	13 \			ispanic Ori	gin? (Sp	acify Yes or No			nerican Indian.	
Sec.	5	t ☐ Never Married 2 ☑ Married	Armed Forces?		F.6	If Yes, spec	cify Cuba	n, Mexican	Puerto	ecify Yes or No Rican, etc.)		Black, Wh		
1 2	ò	3 Widowed 4 Divorced	1 Y Yes 2 ☐ I If Yes, Give Year or Dates:	1952-		1 🗌 Yes	2 🔀 No	Specify:				Specify:	WHITE	
1	2	15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occupa	ation			16b. K	ind of Busines	ss/Industry	_
Del C	Сотріете	(Specify only highest gr Elementary/Secondary (0-12)		F.,\	(Give lite. L	kind of wo DO NOT u	ork done d se retired	during mos I)	t of work	ng			•	
ag E	5	12	College (1-4or 5	3+)	SECU	RITY A	LARM	INSTAL	LER		Р	RIVATE		
		17. Father's Name (First, Middle, Last)				T	18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
To B	o De	SAMUEL POSEY						MARTH	A VAL	LAND I NGH	AM			
Tem		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ng Address	(Street a			I Route Numbe		r Town, State	, Zip Code)	
t'a		BARBARA POSEY/WIFE				WYE CL				ADENA MA				
othe		20a. Method of Disposition	3 81 8	20b. Plac	e of Dispo	sition (Nar	me of		C	Date	20c. Lo	ocation - City o	or Town, State	
y or		1 Departies 5 Cuther (Speci			netery, cren DDECT L	-		1	E /10/	2006	CL IN	TON M	IADVI AND	
in in	-	4 Donation 5 ther (Speci 21. Signature of Funer Service Lice		RESU	RRECTIO			s of Facilit	5/18/ v	2006	CLIN	TON P	IARYLAND	
Suc) han	e Well		F	LECK F	UNERA	L HOME		LAUDEL			2.2.0	
	+		polications that caused	d the death						LAUREL	MARY	LAND @)	&)& Approxima	ıto.
湖 。		23a. Part1. Enfer the disease, or com shock, or heart failure. List only Immediate Cause (Final						9, 000 40					Interval Be Onset and	tween
ian		disease or condition resulting in death)	SEPSIS -	VANCOMY	CIN								1 WEEK	
cal ner		1	Due to (or as	,										
3		Sequentially list conditions,	b. CHRONIC RI			- DIAL	YSIS						5 TEARS	
Fyaminar		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ATHEROSCL		•	VASCUI	VD DI	SEVSE					10 YEARS	
0	Z X	that initiated events resulting in death) Last	C. Due to (or as			VASCOL	AIC DI	SENSE					TO TEARS	
- L	Cal													
9 7			d											
be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome	of pregnanc	v							23d. Date of d	olarosa	
io io	ž.	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pr						Month Month	Day	Year
Jen Jen	200	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			2 011161 (3)2	,do:://							
6		Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the ur	nderlying c	ause give	en in Part I.		23e. Did t	obacco u	se contribute	to the cause of	death?
1	5	DIABETES MELLITUS								101	Yes 2	☑ No 3 □ I	Probably 4	Unknov
potol	e ce													
yd betel amon	直.									24a. Was autop		prior to	autopsy finding: o completion of	availab cause o
ैं द	3									1 🗆 Yes	2 No	death?	s 2 No	
٠. ار	מ	25. Was case referred to medical examiner?	11				0.1			(Check only o				
Ba C	2	1 Yes 2 No	1	ent 2 EF			DA Othe	91: 4 □ Nu		me 5 🗆 Resid			ecify)	
To Be C	<u>-</u>	27. Manner of Death	28a. Date of Inju (Month, Da	ry Year) 28	Bb. Time of Injury		28c. Injury Work			28d. Describe I	how injur	y occurred		
To Bo	- :5	1 ⊠ Natural 5 ☐ Pending	n			М	1 🗆 \	Yes 2 🔲						
C od of oncite	Calion; IC	2 Accident investigation		ing - At home	e, farm, str	eet, factory	y, office			28f. Location (S City or Tov	Street an wn, State	d Number or I)	Rural Route Nu	nber,
alfication To Bo	mication; IC		28e. Place of Inj	c. (Specify)										
led in by the funeral director, page 2 s	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inj											
led in by the funeral director	Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Accident 3 Could not be determined	28e. Place of Inj building, et	of my knowle	edge, death	n occurred	at the tim	ne, date an	d place,	and due to the	cause(s)	and manner	as stated.	6)
Podical Cortification To Do	redical Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28e. Place of Inj building, et	of my knowle	edge, death	vestigation	i, in my op	oinion, dea	d place, th occurr	and due to the	date and	place, and di	ue to the cause	s)
Madical Cartification To Do	redical Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exa	28e. Place of Inj building, et hysician: To the best miner: On the basis o	of my knowle	edge, death	vestigation 29d	, in my op	oinion, dea o number	th occurr	and due to the ed at the time,	date and	place, and di	as stated. ue to the cause	s)
Cortification: To Be	redical Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28e. Place of Inj building, et hysician: To the best miner: On the basis o	of my knowle	edge, death	vestigation 29d	, in my op	oinion, dea	th occurr	and due to the ed at the time,	date and	place, and di	ue to the cause	s)
Madical Cartifloation: To Do	Medical Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28e. Place of Injuding, et buil	of my knowle f examination ated.	n and/or inv	vestigation	, in my op	oinion, dea o number	th occurr	and due to the ed at the time,	date and	place, and di	ue to the cause	s)
Modical Cartification To Do	medical Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of partition	28e. Place of Injudiding, et hysician: To the best miner: On the basis o and manner st.	of my knowle f examination ated.	and/or inv	vestigation	, in my op	oinion, dea number	th occurr	and due to the ed at the time,	date and	place, and di	ue to the cause	s)

ORIGINAL

				Department of Health and M	_		
			1 - Stata Registrar	Certificate of Death		0000	17111
- 35	X 25		Decedent's Name (First, Middle, Last)	Commodition Dodin	Reg. 2. Date of Death	NOCULD	3. Time of Death
à	Physici /Medic		Ingrid L. Pete	ers		Day Year 2006	9:15 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			GOOD SAMARITAND HOSPITA				
7.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	place (State or Foreign ntry)
*	Director		Usual Residence of Decedent	110.	1-8-1	921 G	many
	yland how		10a. State 10b. County 10c. City, To	vn or Location		1	Od. Inside City Limits
	e Ma Sa-f s	ctor	mu 13a	17 more			1 PYes 2 No
	vith th	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	eath v	erai	11. Marital Status 12. Was Decedent Ever in U.S.	21229	ody Voc or No	14. Race - Americ	on Indian
_	r Item	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ You	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
5-0036	2 hours after death with the Maryland atural, or Items 23e or 28e-f show Itel Exanting that by hulffled at	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: UF	rite
۲ ک	C 6 4	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workillife. DO NOT use retired)	ng 16b	. Kind of Business/Inc	dustry
12	within 72 ene. than "na	mpi	Elementary/Secondary (0-12) College (1-4pr 5+)	life. DO NOT use retired) .	N	10+1:	Co Trace
א ס	Hygin Hygin ther ant,	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	ten Sumame)	C TIBUT.
an		To B	Heinz K. Peters	Gret	e B.	Pete	rs
Mary	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 Is marke Injury or other traumatic 8.		Lia Intermant's Name/Relationship (Type, Int) Friend) 19	b. Mailing Address (Street and Number or Rura	l Route Number, Cit	y or Town, State, Zip	Code)
	and 2 ealth m 27		Julia E. Staylor	120 Essexwood	Ct. Es	SCX, MD	21221
saitimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 20b. Place 20b. Place 20c. Place 20b. Place 20c.	of Disposition (Name of Dary, crematory or other place)	ate 20c.	Location - City or To	wn, State
	rtmen rtant: njury		4 Donation 5 Other (Specify) 21. Signature of Prineral Service Libense	y Kedeemer 6-2	-06 0	altimore	mD
g	Depa Impo any i		21. Signature of Authorial Services Liberise	22. Plante and Actions of Facility	atives fu	neral an	deremation
		7	23a. Part I. Enter the disease or complicatings that caused the death. Do shock, or heart failure, it is tony one cause on each line.	Center 2325 york rd not enter the mode of dying, such as cardiac o		10m mu 0	Approximate
	Physician		Immediate Cause (Final disease or condition	1/ 1			Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as a consequence				
	Examiner		Sequentially list conditions, b. Sephic 8	hock			
. 17	led Isit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):			
7	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence	of):			
20/	# × 0	call	d				
200	w requires that the death certifica been signed by the attending ph should be detached for use as th	Medi	IF FEMALE:				
o n	death ce e attendi	lan/I	23b. Was decedent pregnant in the past 12 months 2 1 Live birth 2 Fetal death			23d. Date of delive Month	ry Day Year
	the de y the a sched f	Physician/Med	1 Yes 2 Wo 4 Pregnant at time of death 9 Unknown	5 Other (specify)		WOULT.	Day Foai
7	that ned by deta		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
ecords	requires that een signed b hould be deta	ed by	Autoimmune Plypatin's leading	to Ful Stage liver Dis	ee _{st} 1 □ Yes	2 No 3 Prob	ably 4 Unknown
000	2 5 0	Completed	Idiopathic florombough pedin	ic Puspusa	24a. Was an autopsy	24b. Were autop	osy findings available
<u> </u>	rsician: The law s certificate has b lirector, page 2 s	Com	Gastric Ulcur perforation		performed	death?	npletion of cause of 2 No
VITAI	Physician: this certific	Be	25. Was case referred to medical examiner?	26. Place of Death			
ō	Phys rthis ral dii	2	1 Inpatient 2 ENVO	utpatient 3 DOA 4 Indusing Hon	ne 5 Residence 8d. Describe how in	6 ☐Other (Specify)
0	nding th. r: Afte e fune	ation		Injury Work? M 1 ☐ Yes 2 ☐ No		,4,7,00041104	
UNISION	r Atte	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	8f. Location (Street City or Town, Sta	and Number or Rura	Route Number,
2	iltal o irs aft ral Di iled in						
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Physician: To the basis of examination as (Check only one) 2 Medical Examiner: On the basis of examination as and manner stated.	e daath occurred at the time date and place, a nd/or investigation, in my opinion, death occurre	nd dua to the cause of at the time, date a	(s) and manner as shand place, and due to	the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, L	Day, Year)
	, ,		Minguram M.D.	P 13943	1	5/29/	2006
	N		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	210 0	1 / / -	- 21239
			J. Hingosam MD	5601 Loch Fau	en Blvd	1)417	MUCHO
	Sta Registra		31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Parell .			/
		2	£ 15 M3.42 2 1 16	E. SA WILLIAM A. F.			

INGRID

		1 - For State Registrar	State of Marylar		artmen			ind M	Re	g. No.	2006	17415	5
Phys	ician	Decedent's Name (First, Middle, Last) RUTH ELEANOF	PRICE						2. Date of Deat Month May 27	-	06 Year	3. Time of Death 3:30 P M	
/Me Exan	dical niner	4a. Facility Name (If not institution, give s Future Care			4b. City,		Location of Balti	f Death		-	ounty of Dear	th	
Funer: Directo			M 2 🟋 7. Age (In yrs.		If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth OCC • 4, 1	9 2 6	9. Biri	thplace (State or Foreign punity) aryland)
a-f ahow	ctor	Usual Residence of Decedent 10a. State 10b. County MD	10c. Ci	ty, Town or Lo	Balt	imoı	re					10d. Inside City Limits 1X Yes 2 □ No	
with the a or 28	Dire	10e. Street and Number 1631 Park Avenu	e Ant 16		10f. Zip		2121	7	10	0g. Citize	on of What Co USA	ountry?	
ING 21215-UU36 be filed within 72 hours after death with the Maryland hat hygiene. In thygiene than "natural", or Itema 23a or 28a-1 ahow event, it a Medical Evantinar must be notified at	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 Yes, Give Year or Dates:		Was Deced If Yes, spec	dent of Hi cify Cuba			ecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify:		
Maryland 21215-0035 nd 2 should be filed within 72 hours af the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Event	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Cret	rk done d se retired,	ation Juring most)	of worki	ng			Industry nt Of sing	_
	To Be C	17. Father's Name (First, Middle, Last) Charles Price	ce						(First, Middle, M UNKNO		iumame)		
Marylar 12 should be h and Menta 7 is marked traumetic ex		19a. Informant's Name/Relationship (Type Donald Little-C			-				d Apt.1	-			1
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menia Important: if Item 27 is marked any Injury or other traumatic ex		20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. I	Place of Disponentery, crei	osition (Nan matory or o	ne of ther place	e)		ate	20c. Loca	ation - City or		1
Balti permit. Departm Imports	once.	21. Signature of Funeral Service License	Fadde	88	2. Name an	d Addres	ss of Facility	EVA	NS CHAPEL -Parkv	FM	EMORIES e, mar	yland 212	3
Medicale be executed /Medicale be executed /Medicale be executed /Medicale and extremelt extremelt extremelt with the purial-transit	lcal Examiner		Due to (or as a consect	rocy (control of)	er the mod	le of dyin	such as o	cardiac c	r respiratory arre	est,		Approximate Interval Batween Onset and Death	
Geath cert death cert e attendin id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					23	d. Date of de Month	livery Day Year	
cords, P. w requires that I been signed by should be deta		CAA	tributing to death but not res	sulting in the u	inderlying c	ause give	en in Part I.			acco use		o the cause of death?	
Division of Vital Records, P.O or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.									24a. Was an autops perform	y	prior to death?	utopsy findings available completion of cause of 2 No	
VITA sician s certifi	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	FB/Outnatie	nt 3 🗆 DC	Cthe			n <i>(Check only on</i> me 5 ☐ Reside		Other /See	0.64)	_
ion of nding Phy ath. r: After this e funeral c	atlon; To	the same of the sa	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe ho			City	-
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory	y, office			28f. Location (St. City or Town	reet and , State)	Number or R	ural Route Number,	
Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	niciae. To the best of my known of the basis of examinating and manner stated.	owledge, deat ation and/or in	th occurred evestigation	at the tim , in my op	ne, date and pinion, deat	d place, a	and due to the ca ed at the time, da	tuse(s) a ate and p	nd manner as place, and due	s stated. to the cause(s)	
To the I within 2 To the Complet	Me	29b. Signature and fitte of certifier	scholon		290	c. License	number	~	29	9d. Date	signed (Mont	h, Day, Year)	
V		30. Name and address of person who co	mpleted cause of death (Itel			Balt	imor	e,Ma	aryland	21	202		
	State istrar	31. Date filed (Month, Day, Year)	36 Registrar's Sign		ente								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:200 M 2006 **Physician** ummer Ma needo Ane /Medical 4a. Facility Name (If not institution, give street and number)

Bel Au Heuth t Ce 4b. City, Town, or Location of Death 4c. County of Death Examiner AII enab tal told Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. Months Hours 1 M 2 F 3 -7532 217-26 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 100 MN Director Har TOYC lingtor 10e. Street and Number 10f. Zip ¢ode 10g. Citizen of What Country? Koac ioloinson Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 TNo If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 200 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 onemaker none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10150r rnie Jra 19b. Mailing Address (Street and Number or Rural Route Number, City or Fown, State, Zip Code) 21034 19a. Informant's Name/Relationship (Type, Print) Robinson Mill 1846 hd 20c. Location - ty or Town, State velup. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Seremation 3 Removal from State 131/00 * 4 □ Donation = 5 □ Other (Specify) Crematory 22. Name and Address of Ficility 21. Signature of Funeral Service bicenses Forest Hill MO 3 Newport De 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure Immediate Caus (Final disease or cond) in resulting in death) Physician 2015 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate and the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an director, page 2 autopsy πθα? 2 Ω Νο 1 ☐ Yes Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZNo Certification: To 2 ER/Outpatient 3 DOA Ę filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 2 Accident 5 Pending 1 Tes investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

GU Wert MacPhieud

DUBSIJH

31. Date filed (Month, Day, Year)

JUN 0 2 2006

06-03551 Sean Ruffin

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hy

bean Kuisiii		1- For State	tate of Maryland.	-	tment of l		vientai Hygiene	Dog No.	000 1711
Physici		Registrar 1. Decedent's Name (First, Midd	dle,Last)				Date of D Month	Reg No Peath Day Year	3 Time of Death
Medical Exami	ner	Shawn Ro				. City, Town, or Loca	May 25,	2006	2137 hrs
the way		Johns Hopkins Hospi				Baltimore City	ation of Death	4c. County of	Death
Funeral Director		5. Social Security Number 212-86-5763	6. Sex 7. Age 1 X M 2 F	e (In yrs. Ias	st birthday) 33 Yrs		f Under 24Hrs 8. Date of Hours Min. 02–24		Birthplace (State or Foreign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County		10c City, T	own or Location				10d. Inside City Limits
daryland 28a-f show datonee.	tor	MD	NA			Baltimore			1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	I Director	10e. Street and Number 2009 Woodbourne	Avenue			Of Zip Code 21239		10g. Citizen of Wha	t Country?
or death wi	Funeral	11 Marital Status 1 X Never Married 2 M 3 Widowed 4 Div	12. Was Decedent Armed Forces? 1 Yes 2 vorced If Yes, Give Year	Ever in U.S X	If Yes	Decedent of Hispani specify Cuban, Me es 2X No sp	ic Origin? (Specify Yes or Pexican, Puerto Rican, etc.)	White,	
5-0036 led within 72 hours after dygiene other than "natural", the Medical Examine	d by	15. Decedent's Education (Spe	or Dates:	pleted) 1	16a. Decedent's	Usual Occupation ((Give kind of work done	Specify. B	
136 hin 72 hours a' e than "natural	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	during mos	of working life DO	,		
d with ygiene other (Com	12 17 Father's Name (First, Middle	, Last)			Electrician 18.M	n lother's Name (First, Middle		ainance
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica	å	John Ruffin					Rhoda McI		
Baltimore, MD 21215-00 pernit Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Ms	٦	19a Informant's Name/Relations Rhoda Ford	ship (Type, Print)				d Number or Rural Route N venue Baltimore		State, Zip Code)
ore, ss l and of Heal		20a Method of Disposition 1 XBurial 2 Cremation	n 3 Removal from Sta		ace of Disposition	n (Name of cemeter place)	ry, Date	20c. Location - C	ity or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S	pecify:	- 1	Memorial		05-27-06	Randalls	town, MD
Bal permi Depar Impo		21. Signature of Euneral Service	Licensee			ne and Address of F	ome 638 N. Gilm	or St. Balto	MD 21217
Physician	-	23a. Part I. Enter the dis e, or failure. List only le cause	complications that caused on each line.	the death. D					
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	0 1 1111	` '	Head and Le	9			Death
and the same	_	Sequentially list conditions,	b						
—	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated	C						
A ansit		events resulting in death) Last	Due to (or as a conse	quence of):					
760, icate be executed physician and the burial - transit	edical	UNPENDED	XAMENDED ite	n#1,per	ME,g856,6	/14/06 TT			
760, ficate be g physicia the buria	≥	IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, outcom	e of pregna				23d Date of de	livery
P.O. Box 687 that the death certific ned by the attending p	sician/	past 12 months?	4 Pregnant at t	ime of deat	2 Fetal Dther	death 3Ed (Specify)	ctopic pregnancy	Month	Day Year
. Bo	₹	1 Yes 2 No 9 Uni	9 Unknown	h. d. a ad a a	10 - 1 - 0 1				
8 50 0	<u>a</u>	Part II. Other significant condit	ions contributing to death	but not rest	uiting in the und	eriying cause given			te to the cause of death? Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director; page 2 should the fine of the funeral director; page 2 should be a second to the funeral director; page 2 should the funeral director; page 2 should be a second to the funeral director; page 2 should be a second to the funeral director; page 2 should be a second to the funeral director; page 2 should be a second to the funeral director; page 2 should be a second to the funeral director.	Completed						24a. Was		re autopsy findings available
tal Reco cian: The law certificate has	dmo	Minutes						ormed? dea	r to completion of cause of th? Yes 2 No
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of Viring Physical After this	္ပ	1 Yes 2 No 27. Manner of Death	1 Inpatier		R/Outpatient 3 8b. Time of Inju		The state of the s	Residence 6 (Other
ion of tending Pt eath. tor: After the funeral	Certification:	1 Natural 5 Pend	found:	ar) F	OUND: 2102 hrs		2 ✓ No Subject she		
ivisi or Att after de Directe in by t	ifica	. =	original /			actory, office buildin	ng. etc. 28f Location or Town,	(Street and Number of	or Rural Route Number, City
Div ospital or hours afte neeral Div		4 V Homicide	(Specify) Alle				rear of 200	9 Woodbourne	Ave, Baltimore City ,
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	edical	(Check only Certifying Pr	nysician: To the best of my miner: On the basis of exam						
F × 5	Me	29b. Signature and title of certifie	and manner stated.			29c License num	mber	29d. Date signed	(Month, Day, Year)
		Card	L Hal	la	V	O.C.M.E.		May 26, 2006	;
7		30. Name and address of person Carol Allan, MD Ass	who completed cause of de sistant Medical Exam		· ·	eet, Baltimore,	MD 21201		
St	ate	31. Date filed (Month, Day Year)	3# Registrar			-ot, balantole,	2 120 1	- <u> </u>	
Regist	rar	JUN 0 2 2	006	H.	frank.				
DHMH 17 Rev 1/20	01		-		ORIGINAL				

OCME 2006

			For State	State of Maryland / Depa		ental Hygie	ne2006	7 100
	Physici	an	1. Decedent's Name (First, Middle, Last) Vivian	- C856-6/02/06 JH Ramey	imodio oi bedin	2. Date of Death Month 05	Day Year 23 06	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death	2029 м
a Mar	Funeral Director		5. Social Security Number 6. Sex 123-46-8331	ral Hospital 7. Age (In yrs. last birthday) M 2🖾 F 50 Yrs.	Olney If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 09 06 5	ar) 9. Birth	place (State or Foreign ntry) York, N.Y.
more, Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If team 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other treumstic event, Ite Musical Exam for matter to other progress.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montgome: 10e. Street and Number 735 Sligo Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur (Specify only highest grade (Specify only highest grade International Part of County (Specify only highest grade International Part of County (Specify only highest grade International Part of County (Specify) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Ty) Hubert Sumner/Specify) 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	#303 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give Year or Dates: Cation College (1-4or 5+) De, Print) 16a. Deced (Give Iffe.) Prog	Spring 10f. Zip Code 20910 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto II) 1 Yes 2 No Specify: Ident's Usual Occupation kind of work done during most of working of work done during most of working the specify of the specify. 18. Mother's Name Celia Song Address (Street and Number or Rura Slico Ave. #303 Singuistion (Name of matory or other place) [emorial PK 5-30-12. Name and Address of Facility MArs	ncfty Yes or No-Rican, etc.) Ing (First, Middle, Maid Smith Route Number, Cit late 200 -06 Late Shall's Fi	Citizen of What Cou USA 14. Race - Amen Black, White, Specify: Whit . Kind of Business/Ir J. S. Gover fon Sumame) ty or Town, State, Zij nc. Mi. 2 Location - City or Tondover, Mill uneral Hor	can Indian, etc. ce industry connent co Code) ingl() own, State cone
), 09/	Physician /Medical Examiner popularitansit	dical Examiner	23a. Part I Entewithe disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do not enter e cause on each line. Sup 8i S Due to (or as a consequence of): Purity Due to (or as a consequence of): Cell ulity Due to (or as a consequence of):	er the mode of dying, such as cardiac of the mode of dying the such as cardiac of the mode of dying the such as cardiac of the mode of dying the such as cardiac of the mode of dying the such as cardiac of the mode of dying the such as cardiac of the mode of dying the such as cardiac of the such as	r respiratory arrest,	2	Approximate Interval Between Onsel and Death PWS 2 WKS 2 WKS
O. Box 6	it the death certificate by the ettending phy ached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
	ine law requires ina ate has been signed page 2 should be dei	Completed by	renal rail	tributing to death but not resulting in the under the control of t	agulcputu		24b. Were auto prior to co death?	oppy findings available impletion of cause of
<u> </u>	Hospitel or Attending Prystcian: In 44 hours after death. Funerel Director: Alter this certificate tely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Impatient 2 EP/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, str building, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence 28d. Describe how in	and Number or Rura	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examination Medica	idicien: To the best of my knowledge, death ler: On the basis of examination and/or in and manner stated. I WO MM Impleted cause of death (Item 23a) (Type.	vestigation, in my opinion, death occurre 29c. License number	ed at the time, date :	and place, and due to Date signed (Month,	Day, Year)
Gy.	Sta Registr		31. Date filed (Month, Day, Year)	3 Registrar's Signature	riuce Philip	ov. olne	ey MD 2	20832

			State of Maryland / Department of Health and N Certificate of Death	dental Hygi	200	15 171.10
		-	1. Decedent's Name (First, Middle, Last)	2. Date of Deatl	g. NoC U U	3. Time of Death
	Physic		ELEANOR JOSEPHINE SCHAEFER	Month MAY	Day Y	^{(ear} 006 6:20P ^M
	/Med Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of	
	Zaditi		Genesis~Perring Parkway N. H. Baltimore Count	у		imore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	1	219~22~2000 1 M 2 X F 92 Yrs. William 2 Says Trous William 2 Yrs. William 2 Says Trous William 2 Yrs. William 2 Says Trous William 2 Yrs. Wil	Nov. 16	,1913	Maryland
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	h the Maryland r 28e-f show	tor	Maryland Harford Jarrettsville Harford	County		1 ☐ Yes 2 ☐ No
	ith the or 286	lred	10e. Street and Number 10f. Zip Code	10	g. Citîzen of Wh	at Country?
	23a c	la C	3523 N. Furnace Rd. 21084		USA	
	er deg	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Status of Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc.
	nrs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Specify:	White
	2 hou	ted	15 Decedent's Education 16a Decedent's Usual Occupation	vina .	16b. Kind of Busi	ness/Industry
	212 Ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	\"''g		
	illed will Hygier other th	Be Completed by Funeral Director	6 yrs. N/A Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, N		ing-Own Home
	Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. It is marked other than "natural", or items 23a or 28e-1 show traumatic event, the Medical Examinar must be notified at	Be			aloen Sumame)	
	should Me mark	2	George Hermanau Kose Fr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		City or Town, St	ate, Zip Code)
	Md 2 lith a 27 ls		Albert W. Schaefer, Jr. (Son) 3523 N. Furnace Rd.	Jarretts	ville. M	ld. 21084
	altimore, rmit. Pages 1 a partment of Hes portant: If Item y injury or otherce.		20a. Method of Disposition 1			ity or Town, State
	Pages Pages ment of a		4 Donation 5 Other (Specify) Parkwood Cemetery 6-2-		Baltimor	
	Baltimorr permit. Pages: Department of P Important: If Ite any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd.	Home		03.000
	40340		CO. Code Followship discontinuous about an used the death. Do not extend to made of this much as an discontinuous		-4	Anneovimato
_	Dhusisian	4 12	shock, or heart failure. List only one cause on each line.	Cus	1.312	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):		12	er yes
X	Examiner		1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			Gens
W	\$ 8 A	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			1
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AB	760, (1) to be executed ysicien and burial-transit	calE	d.			
5	68 tifficate g phy as the					
N	Box sath cert at lendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. tf yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	•
	D. E ne dea the at hed to	Completed by Physician/Med	1		Monti	I Day 16al
O.R	P.O.	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
EMNO	Vital Records, stein: The law requires t certificate has been signer rector, page 2 should be verector, page 2 should be verector.	d b	Seveni Concertia	1 ☐ Ye	s 2□No 3	☐ Probably 4 ¬ nknown
U	aw rec	olete	legression	24a. Was ar		ere autopsy findings available
17	Re la The la te ha bage 2	E		autopsy perform	ned? dea	or to completion of cause of ath? ☑Yes 2☐ No
-	ital	Be	25. Was case referred to medical 26. Place of the sammer?	th (Check only one		
	of V hysic this ce	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing H	ome 5 Reside		
	Division of to Attending Phy after death. Director: After this in by the funeral of the funeral	lon:	27. Mann Death 1 Natural 5 Pending (Month, Day Year) No Natural investigation (Month, Day Year) 28a. Date of Injury 28b. Time of 28c. Injury at Work? No Natural investigation M 1 Yes 2 No	28d. Describe ha	w injury occurred	
	vision vittems death ctor:	ficat	3 Suicide 6 Cottoning to determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Str	eet and Number	or Rural Route Number,
0	Div	Certification:	4 ☐ Homicide determines building, etc. (Specify)	City or Town	, State)	
	Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as th	edlcal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the ca	use(s) and mann	ner as stated. d due to the cause(s)
	thin 2.	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number			Month, Day, Year)
	¥ ¥ ¥ 8		MAPCUC-8 0008350		14	3/2006
	0.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
E:	V		CRACITO V. PATE GO BLET. K	ARTO	12At	102/239
	S Regis	tate	31. Date filed (Month, Pay, Year) 2 2005 32. Registrar's Signature			
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			1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	6 17420
•	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Parthenia Sm. H 4a. Facility Name (If not institution, give street and number) SINAI HOSPITA BALT MORE 2. Date of Death Month Yea Yea Yea Yea Ab. City, Town, or Location of Death BALT MORE W	eath / M
4	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Yrs. 7. Age (In yrs. last birthday) 1 Yrs. 8. Date of Birth (Month, Day, Year) 1 Yrs. 9. B 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Super Part Min. Super Part Months Days Hours Min. Min. Super Part Months Days Hours Min. Min. Super Part Months Days Hours Min. Months Days Hours Min	Birthplace (State or Foreign Country)
her	the Maryland 28a-f ehow notilied at	ctor	10a. State 10b. County 10c. City, Town or Location Baltmore	10d. Inside City Limits 1
art	death with the ma 23a or 28a rmust be not	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What (54
9	hours after des tural', or Itema al Examinar m	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 Let No Specify: Specify: Specify:	merican Indian, hite, etc. If me com ment on
1+1 (21215-003)	within 72 ene. than "nai	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RPN 16b. Kind of Busines	,
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	e//
	ss 1 and 2 sho of Health and I Item 27 Is ma r other traums		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 20b. Place of Disposition (Name of Date 20c. Location - City or Town)	21223
Baltimore,	Page nent o ant: If ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lite uses 22. Name and Address of Facility 5 Funeral Service Service 22. Name and Address of Facility 5 Funeral Service Servi	
Ba	permit. Depart Import any Inj		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
9	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. MYOCARdiA IN FARCION Due to (or as a consequence of):	
8760, 🚣	sate be executed by sicien and the burial-transit	dical Examiner	d.	
P.O. Box 68	The law requires that the death certificate tite hes been signed by the attending physoage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Month	delivery Day Year
rds, P	w requires that been signed t should be deti	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End STAge Renal DiseasE 1 Yes 2 No 3 III	to the cause of death? Probably 4 Unknown
il Reco	The law recate hes bee	Complet	24a. Was an 24b. Were autopsy prior to death 1 Yes 2 1 No 1 2 Yes	autopsy findings available o completion of cause of ?
of Vita	ding Physicien: The lavh. h. Atter this certificate hes funeral director, page 2:	To Be	1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Sp.	pecify)
Division of Vital Records,	r Attending P ter death. Irector: After I by the funera	Certification:	27. Manper of Death 1 StNatural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 1 Yes 2 No 28b. Injury at Work? 1 Yes 2 No 28b. Injury at Work? 1 Yes 2 No 28b. Injury at Work? 1 Yes 2 No 28b. Injury at Work?	Rural Route Number,
О	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	icai Cer	29a. Certifier (Check only (Ch	as stated. ue to the cause(s)
	To the I within 2: To the I complet	Medical	and the state of t	nth, Day, Year)
	N		30. Name address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK BURKE, JEMN 2401 W. Belvedede AVE BALL	2121S
Į)	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 2 2006 Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Shanen brook lav 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perring Park Ville Baltomore Kerk Conte 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Fellonth Day, Year) 8 6 Sex **Funeral** 1 M 2 F Days Hours Min. 218-07-8237 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Ie marked other then "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10a. State 10b. County 1 Yes 2 No Maryland N/A Baltimore City Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 1651 East Belvedere Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Home Maker Own Home 17. Father's Name (First, Middle, Last)
Frank Bostwick 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Kibby Bostwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 le any injury or other treu. 2826 Cubhill Road, Baltimore Maryland, 21234 Mr. Richard Shaneybrook (Son) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel 5-31-06 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee P2. Aceful Alternatives Funeral & Cremation Ctr.P.A. 2325 York Road, Timonium Maryland, 21093 2/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician arebovasc disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine / Spug The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ No 24a. Was an certificate has autopsy periorm 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26, Place of Death (Check only on examiner? ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No nerel Director: A 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and itle of certifie 29d. Date signed (Month, Day, Year) DO059423 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 Ndid Fienberg M.D. Wentworth Road, Parkville Maryland, 21234 32 Distrar's Signature State Registrar

5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Funeral Deys 1 □ M 2 対 F Yrs. July 21, Director 218-74-3550 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mental Hygiene. Important: If itam 27 is marked other than "natural" any injury or other traumatic excessions. 10a. State 10b. County 10c. City, Town or Location Catonsville Maryland Baltimore Director 10e. Street end Number 10f. Zip Code 5/27/06 9:00 PM 715 Maiden Choice Lane CR516 21228 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) 5+ Elementery/Secondary (0-12) Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lella May Thompson Henry C. Houck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4761 Montgomery Road; Ellicott City, MD 21043 Friend Donald Baugher, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or dear feations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Physician/Medical Examine ettending physician end for use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed auasanca this certificate has ral director, page 2 Attanding Physician: Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Certification: Injury et Work? 1 Naturel 5 Pending investigation To the Hospital or Attandin within 24 hours efter death. To the Funeral Director: At completely filled in by the fu

1. Decedent's Name (First, Middle, Last)

4a Fecility Name (If not institution, give street end number)

Oak Crest Village

MARY

Physician

/Medical

Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

6/9/06 Fikesville, Maryland 22. Name and Address of Fecility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 10 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) 32. Registrer's Signeture **ORIGINAL**

2. Dete of Deeth

May

4b. City, Town, or Location of Deeth

Parkville

If Under 24 Hrs.

Day

USA

2006

4c. County of Deeth

10g. Citizen of Whet Country?

Specify:

Own Home

16b. Kind of Business/Industry

20c. Location - City or Town, State

Baltimore

1911 Maryland

Race - American Indian, Black, White, etc.

9:00 PM

10d. Inside City Limits 1 ☐ Yes 2X No

Birthplace (State or Foreign Country)

White

27,

DHMH 16 Rev 6/95

2 ☐ Accident

3 Suicide

edical

State

Registrar

4 I Homicide

(Check only

29b. Signatore and title of certifier

31. Date filed (Month, Day, Yeer)

JUN 0 2

2,006

6 Could not be determined

			1 - State Registrar	laryland		rtment of F			Reg. No. ZUU	6 17423
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Richard W. Shaw, Sr					2. Date of De Month	30 200	6/0:00 P.M
	Examin	er	4a. Facility Name (If not institution, give street and number ST AGNES HOSPITI	AL		4b. City Town, o	+10	ORE	4c. County of De	
	Funeral Director		136-10-8224 1∰M 2□F	ge (In yrs. Ia	Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8. Date of Bi (Month, D. Sept. 2	5,1916 Nev	inthplace (State or Foreign Country) V Jersey
	ith with the Maryland 23a or 28a-1 show	ector	Usual Residence of Decedent 10a. State		Town or Lo	ille				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the	Dire	10e. Street and Number 1931 Rockwell Avenue			10f. Zip Code 21228	2		10g. Citizen of What out to USA	Country?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, it a Medical Examinar must be notified at 900s.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 □ Yes 2 □ 11 Yes . Give Year or Dates	:? ≹N o	i		lispanic Ori an, Mexicai	igin? (Specify Yes or N n, Puerto Rican, etc.)		nerican Indian, nite, etc. nite
Maryland 21215-0036	ithin 72 ho ie. ien "natur Medicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or	r 5+)		ent's Usual Occup kind of work done OO NOT use retired		t of working	16b. Kind of Busines	ss/Industry
2	filed wi Hygien ther th	Con	17. Father's Name (First, Middle, Last)		кеат	Estate Ag		er's Name (First, Middle	Realty	
/Jan	uld be Mental irked o	To Be	Frank G. Shaw				C	lara V. Sis	sto	
Mary	d 2 sho th and i 7 ie me traume		19a. Informant's Name/Relationship (Type, Print) Richard W. Shaw, Jr. Son			,		er or Rural Route Numb New Freedo	om PA 173	
	s 1 and of Healt item 2 other		20a. Method of Disposition	20b. Pla		sition (Name of natory or other place	The second second	Date	20c. Location - City	
Baltimore,	Pege Iment c tant: If Jury or		1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	6	Cath	edral Cer	n. (5/2/2006		, Maryland
Balt	Departition Departition on the popular in po		21. Signatu of Fineral Service Counsel	Mola	290 F	. Name and Addre uneral He 630 Edmoi	ome ondson	vSterling A f Catonsvil Avenue: Ca	Ashton Schw Lle, Inc. Atonsville,	ab Witzke MD 21228
8760, <	Physician / Medical Examiner prints the prints transit the prints transit the prints to the prints the prints to t	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequi	ence of):	eriese/	erst	ie Vasou	lar Disc	Onset and Death PLICE Up Known
1/2 D 0.0. Box 68	requires that the death certifica een signed by the attending ph hould be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	telivery Day Year
rds, F	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death	but not resul	ting in the ur	nderlying cause giv	en in Part I		tobacco use contribute Yes 2 \(\text{No} \) No 3 \(\text{O} \)	to the cause of death? Probably Joknown
, Rico	The law cate has b page 2 s	Completed						100	opsy prior to death'	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
35	Physician: this certific ral director,	То Ве	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa	tient 2	R/Outpatien	t 3 DOA Oth	or	e of Death Check only ursing Home 5 Res	one sidence 6 □Other (Sp	pecify)
Sion of	nding ath. r: After ie funer	Certification; 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Day Year)	28b. Time of Injury	M 1		28d. Describe	how injury occurred	
Divi	rs after craft after craft Direct led in by	Certifi	determined 250. Place of I	njury - At nor etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		City or To	(Street and Number or own, State)	Hurai Houte Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	ledical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best one and manner of the cartifying Physician: To the best one of the cartifying Physician: To the best of the cartifying Physician: To the cartif	of examinati		estigation, in my o	pinion, dea		, date and place, and d	ue to the cause(s)
	with Conf	Ň	29b. Signature and title of certifier	yen	m	29c. Licens	e number	849	May 30	nin, Day, Year)
	Sta Registr		30. Nam and address of person who completed cause of the service o	trar's Signate	5 /10	expital	900	Octon F.	Lepus Ba	Minore Maryland

		ı	1 - For State Registrar	State of I	Marylan		artmer <i>rtificat</i>		ealth and M Death		giene 2	006	17424
	Physici /Medio		Decedent's Name (First, Middle, Last) MILDRED		R.	9	SHAPI	RO		2. Date of Dea Month May 31	Day	Year	3. Time of Death 12:31 P M
	Examir		4a. Facility Name (If not institution, give s	treet and number	er)		4b. City,	Town, or	Location of Death		4c. Count	y of Death	1
	·		Greater Baltimor				14 () = 3 -		owson			imor	
	Funeral Director		5. Social Security Number 6. Sex 212-09-3477	M 2 1 F		last birthday) 91 Yrs.	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 02/17)	1915	9. Birth	place (State or Foreign untry) MD
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	with the Maryland e or 28a-f ehow be notified at	ctor	MD BALTI	MORE					BALTIMOR	E			1 ☐ Yes 2 🙀 No
- 0	or 28	Dire	10e. Street and Number	01.5			10f. Zip	Code	01.000		10g. Citizen of	What Cou	•
0	e 23e	erai	16 RIVER OAKS CIR	LLE 2. Was Decede	ent Ever in II	S 13	Was Dece	dent of H	21208	ecify Yes or No.	14. Ba	ce - Amer	USA ican Indian,
1/d(e	urs after de	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	as? [X]No		If Yes, spe		ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Speci	ck, White	
\\\ 215-0		Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4	or 5+)	(Give	dent's Usu kind of wo DO NOT u	rk done d	during most of work	ing	16b. Kind of E		ndustry
- 2	D 00	ပိ	17. Father's Name (First, Middle, Last)			HOME	MILL		18. Mother's Name	e (First, Middle,			
SIC Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event.	To Be	JOSEPH				SONSK		FANNIE				WEINBERG
	2 4 5 E		19a. Informant's Name/Relationship (Type CAROL LANDSMAN /	oe, <i>Print)</i> DAUGHTE	R		-		CIRCLE -		-		
d a	s 1 and 20 Health litem 27 r other tr		20a. Method of Disposition		1 /	Place of Dispo	osition (Na matory or	me of other plac	e) [Date	20c. Location	- City or T	Town, State
Shall	Page iment tent: it		1 X Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)		BET	TH JAC				1/2006			G, MD
0.00	permit. Pages Department of the Important: If its ony injury or or once.		21. Signature of Funeral Service License	7					ss of Facility SO TERSTOWN	L LEVIN ROAD -			
760	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseq	cavaja uence of): Malnu uence of):	1 lv		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Batween Onset and Death
Division of Vital Records P.O. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 No 9 □ Unknown		h 2 ∏Feta ntattime of d	Ideath 3[⊒Ectopic p ⊒ Other (s _i					ate of delin	very Day Year
م م	lires that slgned b	d by Pt	Part II. Other significant conditions con		th but not res	ulting in the u	underlying	cause giv	en in Part I.		obacco use con ′es 2 □ No		the cause of death?
al Recor	i: The law requires the create has been signed; page 2 should be d	Completed by	Right Pland		m							Were aut prior to c death? 1 \(\text{Yes}	topsy findings available ompletion of cause of
×.	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ationt 2	ER/Outpatie	nt 3□ D	Oth	26. Place of Deat er: 4 ☐ Nursing Ho			her (Case	
on of	ding Phy h. After this funeral d	tion: To	27. Manner of _eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time o Injury		28c. Injun Wor	y at k? Yes 2 □No	28d. Describe I			iry)
Divisi	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of building	f Injury - At h	ome, farm, st	reet, factor	y, office		28f. Location (S City or Tox		ber or Ru	ral Route Number,
	the Hospitel or nin 24 hours affe the Funerel Dir npletely filled in	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)		is of examina								
	To th within To th comp	Me	29b. Signature and title of certifier	0.11	10				e number		29d. Date sign		
			& C Guenaus	es p				0006	0248		05/	31/	2006
	ih		30. Name and address of person who co			- 4	Print)		Balhamore,	MD 2	1204		
	St.	ate	31. Date filed (Month, Day, Year)		North (smeet		MINNIE	111/	7-7-1		
	Regist		JUN 0 2 201			K A	reck	<i>*</i>					

			For State Registrar	State	of Marylar		artment rtificate			ınd M	ental H	ygier Reg. I		6 1	7425
I	Dhorie		1. Decedent's Name (First, Midd	fle, Last)							2. Date of Month		Day Year		e of Death
	Physici /Medi		DOUGLAS	SMITH SH	EORN		_			1	MAY	28,	2006	11:	15A ^M
	Examir		4a. Facility Name (If not institution				4b. City, T	own, or Lo	cation of	f Death			4c. County of Dea	ith	
			National Insti	+	+			theso		1411			Montgom	ery	
	Funeral Director		5. Social Security Number 249–08–6655	6. Sex 1⊠ M 2 ☐ F	7. Age (In yrs. 45	. iast birthday) Yrs.	If Under 1 Months		f Under 2 Hours	Min.	8. Date of I	Birth Day, Yea 20	9. Bi 1961 Sou	nthplace (Sta	te or Foreign
			Usual Residence of Decedent	<u> </u>	73						Thiri	. 299	1901 Sou	th Car	olina
	yland		10a. State 10b. Count	У	10c. Ci	ity, Town or Lo	cation							10d. Inside	e City Limits
	a-f s	ctor	D.C.		W.	ashingt	ton							181	res 2 □ No
	or 28)ire	10e. Street and Number				10f. Zip C	Code				10g. (Citizen of What C	ountry?	
	23a	ai	5811 Fourth Str	eet, N.W.			2	0011					United	States	3
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar nual be nuitled at ADGS.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed F	2 ፟፟፟፟፟ No live		Was Decede If Yes, specif 1 ☐ Yes 2		anic Orig Mexican, S <i>pecify</i> :	in? (Spe , Puerto F	cify Yes or l Rican, etc.)	No-	14. Race - Am Black, Whi		1,
5-0036	2 hou	ed	15. Decede	nt's Education		16a. Dece	dent's Usual	Occupation	n .			16b.	Kind of Business		
215	n 72	Completed		est grade completed	(1-4or 5+)	(Give	kind of work DO NOT use	done duri retired)	ing most	of working	ng .		nited St		
2121	d with	mo;	Cleriforital y/3000fidal y (0-12)	4	(19401 37)	Execu	ıtive :	Resou	irce	Mana	ager		overnmen		
b	al Hy s other	Be (17. Father's Name (First, Middle					18	. Mother	's Name	(First, Midd	lle, Maid	en Sumame)		
<u> </u>	Ment Ment arked	To	Wiley Sheorn J						Mar	rgare	et Smi	th			
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n traumatic event, the Mad		19a. Informant's Name/Relation		omestic								or Town, State.		_
	and salth m 27		Bernard J. Del	ia/ p	artner				et,				gton D.C		
Baltimore,	Pages 1 nent of H ant: If Ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (State	Place of Dispo cemetery, crer ntgomery	natory or oth Cremato	e <i>r pla</i> ce) P rium	Inc 2	une 006		Be	thesda,	Maryl:	and
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee		1433 Be	Name and thesd thesd	Address d a-Che a. Ma	recility	Robe Chase and 2	ert A. 0814-	Pun 75 3501	phrey Fi 57 Wisco	ineral Onsin	Home/ Avenue
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the deal								·	Approxir	
	Physician		Immediate Cause (Final disease or condition		Respir	antana.	Fai	lure							nd Death
	/Medical		resulting in death)	Due to	(or as a consec	quence of):	(33)	i rine						7	06677
	Examiner		Sequentially list conditions		ntrai T	Pontine	My	elin	olys	20				1 4	eek
	ס ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e n	o (or as a consec	uence of):			~						
	cate be executed oblysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0.	associat	ed lyn	phopu	olife	reti u	t d	5087	lea		5 ma	oth =
8760,	cien a		rosuling in doain, Last	Due to	o (or as a consec	quence of):									
876	physic physic the b	dica		d											
9 ×	ding p	/Me	IF FEMALE:	23c If yes or	utcome of pregna	2004	-								
O. Box	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	birth 2 ☐ Feta nant at time of c	al death 3	Ectopic pred Other (spec						23d. Date of de Month	livery Day	Year
σ.	that the de led by the a detached		Part II. Other significent conditi	ions contributing to	death but not res	sulting in the u	nderlying cau	ise diven i	n Part I		23e Dic	Ltobacco	use contribute to	the cause	of death?
Records,	w requires that been signed should be det	ted by			2020/201101100	John Grand	Tubilying Gat	236 GIVEIT II					2 /⊠ No 3 □ P		
l Rec	The law re cate has be page 2 sho	Completed								_	24a. Wa aut per	opsy formed?	death?	completion of	gs available if cause of
of Vital	sician: T certificat rector, pe	Be	25. Was case referred to medica examiner?	ıl				26	S. Place o	of Death	(Check only				
>	S S	2	1 ☐ Yes 2 ☑ No			ER/Outpatien	t 3 DOA	Other:	4 🗆 Nurs	sing Hom	e 5□Re	sidence	6 ☐Other (Spe	cify)	
			27. Manner of Death 1. Natural 5 □ Pendi	28a. Date (Moi	of Injury nth, Day Year)	28b. Time of Injury	280	c. Injury at Work?		21	8d. Describe	e how inj	ury occurred		
Division	Attending in death.	Certification:		igation not be			М -		2 🗆 N						
ĭŽ	F # F C	THE .	4 Homicide determ	nined 286. Plac	e of Injury - At hading, etc. (Specif		eet, factory,	office		28	8f. Location City or T	(Street a	and Number or Rite)	urai Route N	umber,
	urs a urs a eral [00 0 0 0												
	Hose 24 ho Fun etely f	edical	29a. Certifier (Check only one) Certifyi	ng Physician: To th Examiner: On the l and mar	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at estigation, in	the time, on my opinion	date and on, death	place, ar occurre	nd due to the d at the time	e cause(e, date a	s) and manner as nd place, and due	s stated. It to the caus	B(s)
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Me	29b. Signature and title of certifie				29c.	License nu	mber			29d. D	ate signed (Mont	h, Day, Year)
	F > F 0) 00.	1			1	041	820	3					
	16		30. Name and address of person	who completed cau	use of death (Item	n 23a) (Tvoe.	Print)						ey 29, .	200 k	
	10		JACQUELINE J	ANKA, MI) 10	CENT	ER DE	R, B	ETHE	ESDA	, MD	208	392		
ALC: Y	Sta	te	31. Date filed (Month, Day, Year	107	Registrar's Signa		والمع	-							
	Registr	ar	JUN 0 2	2006	AND A	r Age	No. of Contract of								

		1	1 - State of Maryland / Department of Health and N Certificate of Death		giene Reg. No.)6	17426
	Physicia	an	1. Decedent's Name (First, Middle, Last) Josephine Theresa Stone	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	May 2	7 2006 4c. County		2:30 A M
	Examin	er	Genesis Eldercare Heritage Center Dundalk			ltimo	re
	Funeral Director		5. Social Security Number 190–18–4158 6. Sex 1 Months 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 1 Months Days Hours Min.	8. Date of Bir (Month, Da March	th 19, Year) 2, 1924	Count	ace (State or Foreign ry) nsylvania
111	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	Maryl a-f sho	tor	Maryland Baltimore Dundalk				1 ☐ Yes 2 No
	h with the	ai Director	10e. Street and Number 7232 German Hill Road 10f. Zip Code 21222		10g. Citizen of V United S	/hat Count tates	ry? S
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23s or 28s-f show important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experiment must be notified at once.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Sive Year or Dates:	ecify Yes or No Rican, etc.)	Blac	e - America k, White, e .White	tc.
21215-0036	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Home, Maker	ang	16b. Kind of Bu		ustry
2	filed v Hygie ther t		12 Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle	Own Maiden Surnam	Home	
au	fental fental rked o	To Be	John Gryzlo Mary An			-/	
Maryland	d 2 show th and h t7 le ma trauma		19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Mussard (daughter) 19b. Mailing Address (Street and Number or Rural 1100 Old Mountain Rd.		-		
Baltimore,	ages 1 an ant of Heal it: If Item 2 y or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date /2006	20c. Location -	-	
Baltir	permit. F Departme Importan any injur		21. Signur, of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral	Home of	Dundalk	c, Inc	C•
41	18.18		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			1111	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition The shock of the	Jun	Pin	-Can	Interval Between Onset and Death
概	/Medical Examiner		resulting in death) Due to (or as a consequence of)	0 4 4			year
		er	Sequentially list non-fillions b. Due to (or as a consequence of): cause. Enter Underlying		E		
	ecuted and -transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed bhysicien and the burial-transit	dical E	d.				
9		Medi	IF FEMALE:				
.O. Box	death e ette	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time ot death 5 Other (specify)		23d. Date Mor	e of deliver	y Day Year
rds, P	w requires that the sbeen signed by the should be detache	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contr Yes 2□No	ibute to the	
Vital Record	aw as b	nplet	Malunti h'on	24a. Was	osy yac	mer to com	sy findings available pletion of cause of
a	ilcian: The certificate ha rector, page	e Co	25. Was case referred to medical 26. Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Practice of Place of Pl	Yes	2 No 1	eath?	2 € No
₹	Physician: this certific ral director,	To Be	examiner?		one) dence 6 □Othe	ar (Specify)	
ion of	ding h. After fune				how injury occurre		-
Division	al or Attend s after death I Director: d in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or Tox	Street and Numbe vn, State)	or or Rural	Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the red at the time,	cause(s) and mar date and place, a	nner as sta ind due to t	ted. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, D	ay, Year)
}	1		Muncon, 000835	8	MAY	27	2006
	5		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8403 H	AR	ropi	12	010
- 39	Sta	te	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	MA	my co	JAID	2/23/
	Registr	ar	JUN 0 2 2006 A Sparks				

			For State Registrar	State of Maryland /	-	artment of Hortificate of L		nd Men		ene, 20	06	17427
	Physici	30	Decedent's Name (First, Middle, Last)						Date of Death Month	n Day	Year	3. Time of Death
	/Medic		Dorothy	W.Ison					lay.	24 20	06	3:05 PM
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	Death		4c. County		
				pital		Baltimo		Alles I -		N/A		
н	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 7	Date of Birth Month, Day,	Year)	9. Birthp	
	Director		Usual Residence of Decedent	8'1	110.				07/21/	1418		MD
	land ow		10a. State 10b. County	10c. City, Tox	wn or Lo	cation					1	Od. Inside City Limits
	Mary -f sh	tor	MD N/A	Baltin	MAR	20					:	1 ☑ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	000, 1.1	10	10f. Zip Code			10	g. Citizen of W	hat Cour	ntry?
	h witl		2531 Toller S	treet		21230)		U	SA		
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origi	in? (Specify	Yes or No-		- Americk, White,	can Indian,
9	ours after death with the Marylan rei', or Itams 23e or 28e-f show Examiner must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No		1 33.13 711041	., 0.0.,	Specify		
5-0036		d by	3 ₺ Widowed 4 Divorced	Year or Dates:							Whi	te
5	J within 72 ho jiena. r then "netu	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a e completed)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	urina most o	of working	1	6b. Kind of Bu	siness/In	dustry
2121	within ena. then *	g L	Elementary/Secondary (0-12)	College (1-4or 5+)		sewife				domes	411	
9	Hyg F		17. Father's Name (First, Middle, Last)		icus		18. Mother	's Name (Fir	st, Middle, M	laiden Sumam		
an	D 00	To Be	John E. Kestl	e 0		2	Elma					
Maryland	E E E	-	19a. Informant's Name/Relationship (Ty		b. Mailir	ng Address (Street a			ute Number,	City or Town,	State, Zip	Code)
	1 and 2 s Health ar tem 27 is		John David Wil	Ison 31	8	and Ave,	Lane	drush	CM.	2122	57	
ē,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of matory or other place	2)	Date	2	Oc. Location -	City or To	own, State
Baltimore,	Pages nent of int: If it		1 ☐ Buriał 2 ☑ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	demoval from State				125/06	F	Saltino	RE	GM
alti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License		22	Name and Address			val Se	RYTHES		
m	89 = 8		Vauchn C.	Greene	5	151 Batto	Nati	Pike,	Baltin	rore, N	01	21329
г			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do	not ent	er the mode of dying	, such as ca	ardiac or res	piratory arre	st,		Approximate Interval Between
	Pnysician	į 1	Immediate Cause (Final disease or condition	neumon	ia							Onset and Death
	/Medical Examiner		resulting in death)	Du to (or as a consequence	e of):							
le.	LAGITITICI	_	Sequentially list conditions,	metastat		diseas	e_					
Т	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	a out:							
V	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	e of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	dicai E		4								
189	ficate I g physi as the b	edic										
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy		ne .				23d. Date	of delive	егу
m.	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 Live birth 2 Fetal deat		Ectopic pregnancy Other (specify)				Mon	th	Day Year
P.0	at the de by the tached	hys	9 Unknown	9LJ Unknown								
S,	res tha igned be det	by	Part II. Other significant conditions con				n in Part I.					ne cause of death?
ord	w requir been si should	ted	myeloprolife	erative diso	rat	2V			1 🗌 Yes	s 2 No	3 🗌 Prob	ably 4 Unknown
Vital Records,	has be	Completed							24a. Was an autopsy	, b	rior to co	psy findings available mpletion of cause of
		Con							penformí 1 ∐ Yes 2		eath? □ Yes	2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		24-		of Death (Ch	eck only one))		
of	shys this al dii	2	1 Yes 2 No	1 Annpatient 2 LI ER/C	Outpatien Time of	The state of the s	4 LI Nuis			nce 6 Othe		y)
	fter fter	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	ai 'es 2 ∐ No		Describe not	w injury occurre	ou .	
Division	Vttendii death. ctor: A y tha fu	lica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,	farm, str				ocation (Str	eet and Numbe	r or Rura	l Route Number.
Div	after Dire	Certification:	4 Homicide	building, etc. (Specify)		,		(City or Town,	State)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physics	sician: To the best of my knowledg	ge, death	n occurred at the time	e, date and	place, and d	due to the car	use(s) and mar	ner as si	ated.
	n 24 i	Medical	(Check only 2 Medical Exami	ner: On the basis of examination a and manner stated.	and/or inv	vestigation, in my op	inion, death	occurred at	the time, da	te and place, a	nd due to	the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier			29c. License			29	d. Date signed		
•			Me	EL CO		D 5	857	1		5/31	1200	6
	10		30. Name and address of person who co			*			Dali			D 21229
	10		Lynn Tag			Caton A	tren	ue	DICUT	imore	all	D 01667
	Sta Registi		31. Date filed (Month, Day, Year) 2 2	006 32. Resistrar's Signature	S. A.	ADDRESS.						
	ricgist				P	J. P.					_	

Wilson, Dorothy

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** SEROME II:ID AM WILLIAMS 30 May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore City NA If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Yrs. Director 214.62.5182 51 01.06.1954 MD Usual Residence of Decedent the Maryland 10b County 10c. City. Town or Location 10a State 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be notified at 1 PYes 2 □ No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? M+ ROYAL AVENUE 21216 or items 23a 1600 USA Funerai Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 250 Married 1 ☐ Yes 2 12 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) SHIPVARD LAYMAN STEEL 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fand Mental I ie marked ELLSAH MILLIAMS BELLIAH AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 te (BROTHER) 2727 W. GARRISON AVE. SHERMAN WILLIAMS BALTO. MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION BALTO. MD 06.04.06 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGIN C. GREENE FUNERAL SERVICE 15151 BALTO. NATI. PIKE, BALTO. MO 21229 Vaughn 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Physician days /Medical Examiner Immunodeficiency Syndrome Human Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Polysubstance Abuse 1 Yes 2 No 3 Probably 4 Nonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificete Yes 1 ☐ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 ER/Outpatient 3 DOA After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural To the husping after death.
Within 24 hours after death.
To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 30, 2006 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Zinaman D.D. 31. Date filed (Month, Day, Year) State JUN 0 2006 Registrar

		State of Maryland / Department of Health and Mental Hygiene
	-	State of Maryland / Department of Health and Mental Hygiene 23a, PtI, 24a per Dr. C856, 06/27/06dhb Reg. No. 1742
Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death Month
/Medica	al -	Willie D. Wylie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Examine	er	Singi Hospital of Baltimore Baltimore City n/a
Funeral		5. Social Security Number 6. Sex / 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Director	-	219-38-7050 15 Months Days Hours Min. (Month, Day, Year) 11-1-1942 Country) S. Carolina
yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
the marylan san be notified at	Director	Md Baltimore Pikesville 1 🗆 Yes 2 🗗 Md
with the		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
y li	Funeral	4744 Bonnie Brae Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Wyfi		Armed Forces? 1 Never Married 2X Married 1 Never Married 2X Married 1 Yes, Specify: 1 Y
15-0036 15-thours after dee "naturel", or fems	d by	American
115-	plete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
d 21215-0036 Mylic flow with the Maryland flow within 72 hours after death with the Maryland Hygiene. ther than "natural", or flows 23a or 28a-1 show ont, the Madrell Exercited must be notified at	Completed	12th Tailor Mens Warehouse
ackilling and 2	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Haryland 2 should be and Mental Is marked to summatic even	ပ	Ambrose Wylie 19a. Informant's Name/Relationship (Type, Print) Nancy Wylie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 1s marked other than "natural; or any niury or other traumatic event, Item Marical Estimance.	i	Marian E. Wylie/ Wife 4744 Bonnie Brae Rd., Pikesville, Md 21208
or Head	3	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Itime		4 Donation 5 Other (Specify) Garrison Forest 6/5/06 Owines Mills Md
Balti Permit. Departm Imports any nju		21. Signature of Edneral Septice Licensee 22. Name and Address of Facility Wylie F/H PA of Balto. Co.
0		9200 Liberty Rd., Kandallstown, Md 21133 23a. 241. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Physician		snock, or heart failure. List only on cause on each line. Inflerval Between Onset and Death disease or condition. Inflerval Between Onset and Death disease or condition.
/Medical Examiner		resulting in death) Due to (or as a consequence of):
	-	Sequentially list conditions, if any, leading to immediate b. Hthe suscile sotic Heart Disease. Due to (or as a consequence of):
is a column is a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.
60, %	Exa	resulting in death) Last Due to (or as a consequence of):
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Records, P.O. Box 687. The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the last t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
Geath death death of for it	clai	in the past 12 months? 1
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Cords, P w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
cord w requir	etec	Destriction of American 24a. Was an 24b. Were autopsy findings available
I Re The lav	Completed	autopsy prior to completion of cause of performed? death?
	Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
Division of Vital Records, P.O. for Attending Physician: The law requires that the dather death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	္	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
on o	tlon:	27. Manner of Death 1
Attendent r death	#Ca	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Boute Number)
Div talor rs afte al Dir ed in t	Certification:	4 Homicide building, etc. (Specify) City or Town, State)
	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
o the iithin 2 o the omple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
F 3 F 3	ļ	1/ CARDON DE LA CONTRACTOR DE LA CONTRAC
31		Nikiu tyawal, ND RES-000 May 29, 2006 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Nikhul tyawal MD sina Hopital d Ballimore
V		31. Date filed (Month, Day, Year) 32. Resistrar's Signature
Stat Registra	44	31. Date filed (Month, Day, Year) JUN 0 2 2006 32. Restrar's Signature

Raymond Alexander Willis 06-03581 Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** May 27, 2006 0640 hrs Raymond Alexander 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Suitland Prince George's 5200 Silver Hill Road 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 6 Sex **Funeral** Foreign Months Days Hours Director 587-53-9891 Country) 1 X M 2 23 12/17/1982 Usual Residence of Deceden 10d Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No 23a or 28a-f sho notified at once. Maryland Prince George's Suitland 10f, Zip Code 10g Citizen of What Country' 10e. Street and Number 2604 Fort Drive 20745 ō United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces? Yes 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2X No specify. Specify: Black permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Sales Representative Retail 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Shelvy Ray Willis Be Vera Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelvy Ray Willis, Father 920 Dr. MLK Drive, Starkville, MS 39759 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State Baltimore, Date 1 X Burial 2 - Removal from State Rest Haven Cemetery Starrville 06/01/06 Other Specify -Peques Saltillo, MS Donation 5 Signature of Funeral Service Licensee 22. Name and Address of Facility West Memorial Funeral Home M01113 P.O. Box 2362 Starkville, MS 39760 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure List only one cause on each line Between Onset and /Medical Death a. Gunshot Wounds (2) of Head and Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical 20a-c g857 7-6-06 vt sician a UNPENDED X AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery phy the t 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? à Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of has performed' death? page 1 🗸 Yes this certificate ✓ Yes 2 To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical 26 Place of Death (Check only one Be Other₄ examiner? Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 2 1 🗸 Yes 2 မ 28a. Date of Injury FOUND: 28d. Describe how injury occurred After 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot ___ Natural FOUND: 1 Yes 2 ✔ No 5 Pending To the Funeral Director: May 27, 2006 0625 hrs Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number City 3 Suicide Could not be determined (Specify) Outside 5200 Silver Hill Road, Suitland, Md 4 V Homicide 29a Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) May 27, 2006 O.C.M.E C 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

JUN 0 2 2006

	1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H tificate of I	lealth and Death		giene) (Reg. No.	006	1743	
	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death	
ian ical	William B. Wiser					May	22	2006	14:14	
ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath	4c. Co	unty of Death		
_	Greater Baltimore 5. Social Security Number 6. Se			Towson If Under 1 Year	If Under 24 h	rs. 8. Date of Bir	th	ltimore	lace (State or Fore	
		2□ F 43	Yrs.	Months Days		in. (Month, Da	y, _{Year)} /1963	Coun	yland	
	Usual Residence of Decedent					7 37 30	/ 1000			
Director	10a. State 10b. County		Town or Lo					11	0d. Inside City Lin	
	MD Baltimore Baltimore								1 Tes 2	
	10e. Street and Number 28 Romanoff Court			10f. Zip Code 10g				og. Citizen of What Country? USA		
d by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						
	1 Never Married 2 Married									
	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ No Specify:				Specify: White		
Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo					working	16b. Kind	of Business/Inc	dustry	
mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	()		~~~			
e Co	17. Father's Name (First, Middle, Last)	4		manager	18. Mother's I	Name (First, Middle,			system	
00	William R. Wiser			Mary Meeks						
은					Rural Route Number, City or Town, State, Zip Code)					
	Mary Meeks- mo	ther				urt Bal		·	-	
	20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of	1	Date		ion - City or To		
once. To Be Completed by Funeral Director	1 Esurial 2 Cremation 3 Removal from State Gardens of Faith May 26, 4 Donation 5 Other (Specify) Cemetery						Ros	edale	MD	
	21. Signature of Juneral Service Licenside 22. Name and Address of Facility 8800 Ha.						Harfo	ord Rd	•	
	Kofet O.D.	whether	E	vans Fu	neral	Chapel	Park	ville	, MD 21	
an al	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Hypotension resulting in death)			er the mode of dyin	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Due to (or as a consequence of):									
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Intra-abdominal hemorrhage Due to (or as a consequence of):								nours	
	Cause Disease or injury that initiated events c Campylobacter sepsis							1	nours	
Exa	resulting in death) Last C. Campy TODACCET SEDSTS Due to (or as a consequence of):								TOULD	
ical		d								
lan/Medical	IF FEMALE:									
lan/I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d	. Date of delive Month	ry Day Year	
hysici								WORKE	Day real	
Δ,						23e Did t	23e. Did tobacco use contribute to the cause of death?			
d by							1 Yes 2 No 3 Probably 4 □Unknow			
Certification: To Be Completed						- 1				
						- autor		prior to con death?	csy findings availa npletion of cause	
	25. Was case referred to medical				00 Diama 4 f	1X Yes	2 No	Yes	2 No	
	examiner?							.1		
	27. Manner of Death	27. Manper of Death 28a, Date of Injury 28			Bb. Time of 28c. Injury at			curred	7	
	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation			M 1 ☐ Yes 2 ☐ No						
tific	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (S	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Cer										
	(Check only 2 Medical Exami	sicien: To the best of my know ner: On the basis of examinati	vledge, death on and/or inv	occurred at the ting	ne, date and pla	ace, and due to the	cause(s) and	d manner as sta	ated. the cause(s)	
ical	one) and manner stated.									
Medical	20h Signature and title of	29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)			
Medical	29b. Signature and title of certifier		0			I				
Medical	29b. Signature and title of cartifier 30. Name and address of person who c	1	e	D430	003		May	23, 200	06	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Items 24a, b per doc 3856 6-2-06 vt
State of Maryland / Department of Health and Mental Hygiene 0 0 5 17432 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Eugene 529 A M Mai 2006 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center University of Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1⊠M 2□ F Days Hours Yrs. 350-32-3571 66 January 27, 1940 Michigan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b, County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3603 Stewart Driveway 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Vietnam If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Intelligence Analyst 5+ CIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Oliver Wicklund Anna Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Wicklund / Wife 3603 Stewart Driveway, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 30, 2006 4 Donation 5 Other (Specify) Montgomery Crematorium Bethesda, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) radiation Dneumonitis
Due to (or as a consequence of): month malignant mesothelloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). ASDESTOS EXI that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performed? 25. Was case referred to medical 26. Place of Death [Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Physician /Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760. signed by the a Division of Vital Records, should b certificate has be irector, page 2 s To the Hospital or Attending Physician: : After this certifical funeral director, i within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

28a-f ehow

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Funeral

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Completed

Be

Examine

Physician/Medical

Be Completed by

Certification; To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehov other traumatic event, the Medical Examinar must be notified at

Department of H important: If ite any injury or ot once.

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar

1121

29c. License number D64246

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

no and sorress of person of completed cause of death (Item 23a) (Type, Print) Greane St Baltimore ML

Kimberly M Lumpkins MD
31. Date filed (Month, Day, Year) 32. Projetrar's 32. Appistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) Date of Death Month Day Year Hurshid Yanbaeva 26, 2006 May 6:25PM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Prince Georges' Hospital Center Cheverly Prince Georges' If Under 1 Year 8. Date of Birth (Month, Day, Year) July 7,1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2127 F Uzbekistan 81 None Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Prince Georges' University Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6600 Queens Chapel Uzbekistan Hace American Indian, Road 20782 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Physician Medical 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Ibniamin Yanbaev Zvlia Umidova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6600 Queens Chapel Road, University Park, MD 20782 ace of Disposition (Name of Date 20c. Location - City or Town, State Julia Borniva, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 5/30/06 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brian T. Chisholm Funeral Services of M01113 Dulaney Valley, P.A. 200 Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician Aviedicul **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or hems 23e or 28e-f ehow any Injury or other treumatic event, I'm Medical Examinal must be notified at

altimore, Maryland 21215-0020

/Medical

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Directo

Funeral

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Completed

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Physiclan/Medical Examiner attending physician and for use as the burial-transit ned by the a pe certificate has b lirector, page 2 s rector: After this certific by the funeral director,

The law requires that the death certificate be executed

Hospital or Attending Physicien:

To the

death.

filled in by

Medical

within 24 hours a

To the Funeral C

completely filled

Division of Vital Records, P.O. Box 68760,

Completed by 25. Was case referred to medical examiner? Be ۵ 27. Manner Jeath Certification:

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I

28a. Date of Injury (Month, Day Year)

1 L Yes 2 No 1 ☐ Yes 2 ☐ No

26.	Place	of	Death	Check only	one
				/	

Other: 4 Nursing Home 5 Pasidence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 2 ☐ Medical Examiner: one) itle of perifier 29b. Signature ape

5 Pending investigation

6 Could not be determined

29c. License number D14182 AN3255

29d. Date signed (Month, Day, Yeer)

wpo completed cause of death (Item 23a) (Type, Print)

Hospital:

M. Naficy, M.D. 31. Date filed (Month, Day, Wear) Prince Georges' Hospital Center, Cheverly, Maryland MAD.

1 Yes 2 No

1 Matural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

JUN 0 2 2006

1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

28b. Timle of

Injury

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖯 🛭 🖺 🕤 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 26, 2006 **Physician** Marilvn Ackman 8:40 pm^м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cumberland Nursing Center Allegany Cumberland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, May 21, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months 1 ☐ M 2 🖵 F Yrs. 230-28-6906 82 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Allegany MD Cumberland 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Winifred Road 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Specify: white 1 Yes 2 No Specify: 3 □Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Perry Morton Fielding Morton Grace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Ackman 3009 Hilltop Drive Murraysville PA 15668 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fairview Cemetery 5/31/2006 Port Allegany PA *4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon mo 5145 Luncer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ZUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Inpatient 2 1 ☐ Yes 2 ☐ NO 2 ER/Outpatient 3 DOA ✓ursing Home 5 ☐ Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

burial-transit attending physician for use as the burial Division of Vital Records, P.O. Box 68760 ned by the a been signed by ed bluods or Attending Physicien: after death. Certification: after death. Director: After

filled in by the funeral To the Hospitel 24 hours

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at

filed within 72 hours after

is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than

Pages 1 nent of h

Physician

Examiner

/Medical

ō permit. Page Department of Importent: If any injury or

Baltimore, Maryland 21215-0036

State

Registrar

Medical

6 Could not be

determined

29c. License number

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D36766

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) 30,2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vikramaditya Poonai M.D. 924 Seton Drive Cumberland MD 21502

29b. Signature and title of certifie

3 Suicide

29a. Certifier

4 \(\text{Homicide} \)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 2 To the

			1 - For State Registrar	State of Ma	aryland	-			ealth a D <i>eath</i>	and Mer		giene Reg. No.	00	6	17435	
.5	Physici /Medic		Decedent's Name (First, Middle, Last Helen Alverta Boot								Date of De Month	Day		ear V6	3. Time of Death 11: 40 PM	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	f Death		4c.	County of I	Death		
			76 Double G Drive				McHe	-					rrett			
	Funeral Director		220-10-0072	7. Age	80 (In yrs. Ia	Yrs.	If Unde Months	1 Year Days	If Under 2 Hours		Date of Bir (Month, Da 1y 3,	1925		Birthpla Countr aryl	ice (State or Foreign y) and	
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City,	Town or Lo	cation							10	d. Inside City Limits	-
	eho	ō													1 ☐ Yes 2 🛣 No	
	the A	ect	IN LaGrange 10e. Street and Number		Howe	2	10f. Zip	Code				10a. Citiz	en of Wha	at Countr	v ?	-
	with o	٥	4690 North 225 Eas	-4-								USA				
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	Funeral Director	11. Marital Status	12. Was Decedent 8	Ever in U.S	3. 13.		746 dent of Hi	spanic Orig	gin? (Specify , Puerto Rica			4. Race -			-
	r Iten	Fun	1 ☐ Never Married 2 🖫 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	No					, Puerto Rica	an, etc.)			White, et	tc.	
2	hours after tural', or Ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 X J No	Specify:				Specify:	Whi	.te	
2-003p	J within 72 hours after death with the Marylan jiene. Ithen "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication		16a. Dece	dent's Usu	al Occupa	ition Jurina most	t of working		16b. Kir	nd of Busin	iess/Indu	ıstry	
Z	within 72 ene. then "na!	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT u	s <i>e retired,</i>) -	,		Reci	ceati	on		
7	al Hygien other th	Co	12			Owner	/Opei	cator		1. 1. /=-			ogrou	nd		_
and	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe other traumatic event,	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (Fi	irst, Midale	, Maiden	Sumame)			
<u>Z</u>	2 should be and Mental is marked aumatic ev	ဥ	Harry P. Collier							Hocki						_
Mar	2 sh and len		19a. Informant's Name/Relationship (7)							or Or Rural Ro		-		ite, Zip C	iode)	
e,	and tealth		William P. Booth/I	lusband	20h Pla	4690 ace of Dispo			East	Date			746 cation - Cit	v or Tow	n State	
_			1 X Burial 2 ☐ Cremation 3 ☐ I		ce	metery, crei	natory or i	other place	n l							
timor	t. Pa tmen tant:		4 □ Donation 5 □ Other (Specify,		Gard	lens		_	t _A 19	ay 27,						
g	permit. Page Department o Important: If any injury or once.		21. Signalure of Figural Service Licens	man						Newmantsv:			2153		P.A.	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused ne cause on each lir	ne.	(0)								1	Approximate interval Between Onset and Death	
	/Medical Examiner	io.	resulting in death)	Due to (or as	a consequ	ence of):	200	1)			, and					_
8/60,	ate be executed thysician and the burial-transit	Ical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	ence of):										_
22	ficate pphy: s the			0												
O. Box	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (s					2	3d. Date o Month		y Day Year	
<u>a.</u>	that the ed by detac		Part II. Other significant conditions co	ntributing to death b	ut not resu	Iting in the u	nderlvina	cause give	en in Part I.		23e. Did 1	tobacco u	se contribu	ite to the	cause of death?	
ecords,	w requires been sign should be	ted by								_ [1 🗆	Yes 2	No 3(☐ Probal	bly 4 □Unknown	
r		Completed									1 Yes	psy ormed? 2 \(\text{No}	prio dea	r to com th?	sy findings available pletion of cause of	
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Cthe		of Death (C	2.55	nmer				_
ö	Phys this aldii	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 _ Inpatie		P/Outpatier 28b. Time o				rsing Home	. Describe		Occurred	(Specify)		_
ב	ding I h. After funer	lo	1 Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	м	28c. Injury Work	ດີົ່ Yes 2 ∐ t		. 00001100	non injury	00001100			
Division	at at	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injusting, etc.							Location (City or To	Street and wn, State)	d Number (or Rural	Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical C		rsician: To the best iner: On the basis of and manner sta	f examinati											
	To the To the comp	M	29b. Signature and title of certifier				29	c. License				29d. Date	e signed (/	Month, D	ay, Year)	
) +/ C					K	115	337		2	5/24	1/0	6	
	21		30. Name and address of person who o	ompleted cause of d	leath (Item	23а) (Туре,	Print)			C. Marie				,		
	3		Thomas Johnson, M.	D., 311 N	1. 4th	st.,	Oak.	land,	MD	21550						
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2.5	32. Registr	ar's Signat	ure	A . A	9 _								

		•	For State Registrer	State of Maryland		artment of Hertificate of D		Mental Hy	/giene 0 0	6 17436
	a . M	25	Decedent's Name (First, Middle, La.	st)				2. Date of D	eath	3. Time of Death
	Physicia		Robert Blair Bar	rick Ir				Month May	22 200	6:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De	ath	4c. County of	
W.		.55	25355 Allston La	ne		Hollywo	od		St. Ma	ry's
18	Funeral	3	5. Social Security Number 6. S	ex 7. Age (In yrs. I		If Under 1 Year Months Days		in. 8. Date of B	av. Year)	Birthplace (State or Foreign Country)
_	Director		162-32-2982	64	Yrs.			June	l9 1941 F	ennslyvania
	DO N	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	sho	5	Maryland St. Mary	's H	o11ywo	od				1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	with with	<u></u>	25355 Allston La	ne		20636			United S	states
	within 72 hours after death with the Maryland ene. Itan "natural", or Itame 23a or 28a-f show Ite Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of His	spanic Origin?	(Specify Yes or N	lo- 14. Race -	American Indian,
(0	or Itan		1 Never Married	Armed Forces? 17 Yes 2 No 19 If Yes, Give	58	f Yes, specify Cubar	т, мехісап, Ри <i>Ѕресіту:</i>	ierto Hican, etc.)		White, etc.
21215-0036	nus a	l by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 21 No			Specify:	White
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupa kind of work done d	uring most of v	working	16b. Kind of Busi	ness/Industry
2	ithin	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			Flootwo	mina
2	led w tygien her ti		12 17. Father's Name (First, Middle, Last)	Frect	ronic Tec		Name (First, Middl	Electro e, Maiden Sumame)	
auc	ntal Hed of	Be	Robert Blair Bar					e Jane Fu		
Maryland	hould d Me mark matic	2	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street a			ber, City or Town, St	ate, Zip Code)
Z	d2 s ith an 27 is trau		Donna Marie Barri						l Maryland	
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itame 23a or 28a-f show eny injury or other traumatic event, Ite Madical Examinational Learning and 2020.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place		Date	20c. Location - C	
0L	ages ant of ht: If I		1 ☐ Burial 2X☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Hemoval from State		d-Echols		24/2006	Charlott	e Hall, MD.
Baltimore,	ortar injur		21. Signature of Funeral Service Lice			2. Name and Addres			d Funeral	
B	Depa Depa Impo eny ii		Kyle S. Simon	s M01206	2	2955 Holl	ywood F	Rd. Leona	ardtown, M	laryland 20650
29			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not en	er the mode of dying	g, such as card	diac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	£ 5	opp	A : 00	4	CANCO	2.0	Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conseq	uence of):	9 0.1			· · · · · · · · · · · · · · · · · · ·	
	Examiner		Sequentially list conditions,	b						
	p t	Iner	ri any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	delica of).					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uanca of):					
760,	ite be executed ysician and ne burial-transit	cal E		500 to (01 d3 a conseq	dende dij.					
687	# × 6	edlo		d			_			
×	h certificat ending phy use as th	/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy				23d. Date	of delivery
Вох	atten 1 for u	clar	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		∃Ectopic pregnancy ∃Other (s <i>pecify)</i>			Monti	h Day Year
0	The law requires that the death certifica site has been signed by the attending ph sage 2 should be detached for use as it	Physician/M	9 Unknown	9 Unknown						
٠, ح	es that igned to be det	by P	Part ff. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Dio	I tobacco use contrib	oute to the cause of death?
Records,	w require been sig should b							_ 1□]Yes 2□No 3	Probably 4 Unknown
S	aw requisite been 2 should	Completed						24a. We		ere autopsy findings available or to completion of cause of
ä	The lay	Eo							formed? de	ath? Yes 2 No
Vital	ician: T certifical ector, p	Be C	25. Was case referred to medical examiner?					Death (Check only	one)	
of <	S S	20	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie		4 🗆 14013111		sidence 6 Other	
ם		on:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe	e how injury occurred	1
sio	ten leat tor: the	catl	2 Accident investigation 3 Suicide 6 Could not l		4		Yes 2 □ No	20f Leasting	(Street and Alumba	or Rural Route Number,
Division	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	reet, ractory, onice			own, State)	or Aural Adult Number,
	To the Hospital or A within 24 hours after To the Funeral Direction pletely filled in by		29a. Certifier 1 Certifying P	hysicien: To the best of my kno	wiedge, dea	th occurred at the tim	ne. date and pl	ace, and due to th	e cause(s) and man	ner as stated.
	24 h 24 h Fun etely	edical		miner: On the basis of examina and manner stated.						
	To the within 2. To the complet	₹	29b. Signature and title of certifier	7	1	29c. License	number		29d. Date signed	(Month, Qay, Year)
	/ / .) Jon	25h Ju	hell	2	154/	78	5/3	13/06
7	11		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	, Print)				
	S		David M. Feder			Rd. Holl	ywood,	Maryland	20636	
1		ate	31. Date filed (Month, Day, Year)	32. egistrar's Signa	ature	Y				
	Regist	rar	MAIA4	2006	O A	neuk				

06-03262 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Lee-Ann Bauer 1- For State Certificate of Death Registrar 1, Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 14, 2006 2048 hrs Medical Examiner Carol LeAnn Bauer 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1501 Gordon Cove Drive Annapolis Anne Arundel 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Countr Pennsylvania Months Days Hours Sept. 7, 1945 Director 214-54-8130 60 2X F M Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits Annapolis Anne Arundel Maryland 1 Yes 2 X No 28a-f show , or items 23a or 28a-f shov r must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 1501 Gordon Cove Drive U.S.A. Funeral 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No White 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: other than "natural", <u>≨</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) rmit Pages 1 and 2 should be filed within 72 hous artment of Health and Mental Hygiene vriant: If item 27 is marked or of other trans Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Naval Institute Art Editor 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annabelle Wilker E.H. Lee Bauer Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3334 Avenida Anacapa Garrick Bauer/brother Carlsbad, California 92009 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important; injury or oth Lincoln Crematory 5/17/2006 Brentwood, Maryland Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** 8etween Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical UNPENDED **AMENDED** ending physician use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be deta ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ examiner? Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this ို 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natura 1 Yes 2 No Pending the 2 Investigation Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 15, 2006 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Patricia Aronica-Pollak MD.

31. Date filed (Month, Day

Assistant Medical Examiner

32. egistrar's Signature

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND #26 PER PHYS 5/18/06 CCHD DB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY 16, Physician 2006 8:49A M BIVENS CHARLES EDWARD /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CIVISTA MEDICALCENTER LA PLATA If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, SEPT. 3, 6. Sex 1X M 2□ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months MARYLAND 71 Yrs. 217-30-8643 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 □ No POMFRET Director MARYLAND **CHARLES** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20675 UNITED STATES 7780 MARSHALL CORNER ROAD Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or Items Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE AUTOMOBILE MECHANIC AUTOMOTIVE INDUSTRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil timent of Heelth and Mental H tent: If Item 27 is marked oth jury or other traumatic even LAURA ELLEN FONTAINE JAMES EDWARD BIVENS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7780 MARSHALL CORNER ROAD, POMFRET, MARYALAND 20675 MARGARET BIVENS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or once. RESURRECTION CEMETERY MAY 20,2006 CLINTON, MARYLAND 21. Light of Fymeral Service Light see THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 YDIA C. THORNTON JOHNSON MOO583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -UNE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a cons quence of burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760, by Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ģ 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 3E 1 Yes Division of Vital After this certification funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home State Nursing Home 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification; To this 28b. Time of 27. Manner of Dear 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. D scribe how injury occurred 1. Natural 5 Pending investigation s after us. ral Director: An 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 18, 2006 7:00 PM Frances Lavinia Boyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Record Street Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth March 20, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min Days Hours 1 M 2 XF Maryland 91 213-64-6498 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Michigal Examinar must be notified at 1 Nes 2 No Maryland Frederick Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 U.S.A. 115 Record Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress/Sales Dress Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Frances Droneburg Grover Nelson Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115 Record Street, Frederick, Maryland 21701 Mr. Kevin Quirk/Administrator 20a. Method of Disposition

WBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 22, 2006 Mount Olivet Cemetery Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00255 chard 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) netestelin **Physician** lele /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown is been signed by the should be detached Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes t lirector, page 2 s autopsy performed? 1 🔲 Yes 2 No 2 No 1 Yes Hospital or Attending Physician: After this certifical funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Dimie. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ₺ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director; All completely filled in by the fu М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 31. Date filed (Month, Pay, State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) Amended iten = For State # 26 (perMD), srr, Talbot, 5-12-200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MAY 10 2006 1:14 P MURIEL BLUMENTHAL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot 6008 Ship Yard Ln. Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 208 F Yrs. Director 110-24-9279 84 03-26-1922 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28a-f show the Medical Exactiner must be notified at 1 Yes 2 No Director Maryland Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6008 Ship Yard Lane 21601 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, if a Madical Exertinal. 1 ☐ Yes 2 X No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ð 3 Widowed 4 □ Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Political Worker Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Murie1 Saltonstall Johnson Grymes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 Ship Yard Lane, Bailey'sNeck, Easton, Md. 21601 <u>Susan Mackie / Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/15/2006 1 4 ☐ Donation 5 ☐ Other (Specify) Dover, Delaware Capitol Crematory 21. Signaur, of Funeral Service Lice 22. Name and Address of Facility
Bennie Smith funeral Home 426 Dover Street, Easton, Maryland 21601 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acuté cerebrovascular aceident-Pnysician /Medical Examiner Atheroscierofic heart disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence • Cher (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28c. Injury at Work? the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) i by within 24 hours after To the Funeral Dire 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056659 5/12/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 607 Dutetman LANE EASTON, MD-21601 MUHAMMAD AFZAL 32. Registra Signature 31. Date filed (Month, Day, Year) State MAY 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** May 26 2006 0915 AM Virginia P. Carroll /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil E1kton Singerly Manor Assisted Living Hours Min. 8. Date of Birth (Month, Day, SEPT 30, Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 20 F Director 82 Mary1and 218-12-2810 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ?7 is markad other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be netitied at 1 ☐ Yes 2 No Directo Maryland Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21921 1800 Singerly Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker In Her Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fund Mental F and Mental Mary E. Blansfield William Pippin 2 Jore, M.
Jermit. Pages 1 and 2 sho.
Department of Health P.
Important: If iter any injury P.
any injury P. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 824, Elkton, Maryland 21922 James N. Carroll/Son 20b. Place of Disposition (Name of Cherry Hill Cherry Hill Methodist Cemetery May 31, 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 2006 1 4 □ Donation 5 □ Other (Specify) Cherry Hill, Maryland Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signa ure of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or so a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The taw requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 DNo
9 Unknown Month Day Year ţo. 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2) No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attanding 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death. the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To tha Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and III 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 116 West 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 Registrar 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			Amend #21&22 Per Ana Bd G85					Reg. No 2 0 0	5 17442
П	Physici	an	1. Decedent's Name (First, Middle, Last) Corann Ashby Clatterbuc	·k			2. Date of Dec Month May 25	Day Yea	3. Time of Death 0010
1	/Medio Examin		4a Facility Name (If not institution, give street and number)	.K	4	lb. City, Town, or Lo			
	LXamii		Garrett Co. Mem. Hosp.			0akland		Garrett	
	Funeral Director		218 34 4888 1□M 2聚F 70	(In yrs. last birthday Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct. 25		Birthplace (State or Foreign Country) V
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits
	Mary 11 sh	호	MD Garrett	0ak	land				1 ☐ Yes 21 No
	er death with the Marylen items 23e or 28e-f show iner must be notified at	al Director	10e. Street and Number 5887 Maryland Hwy.		10f. Zip Code 21.550			10g. Citizen of What USA	Country?
Maryland 21215-0020	72 hours after death with the Marylend natural; or items 23s or 28s4 show deal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Wildowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 □ Nevery New Year or Dates:	er in U,S. 13	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2私 No		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify: Wh	
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and	d be f intal h	Be c					L. Ril		
<u> </u>	Should nd Ma mark imatic	ို	Charles E. Ashby 19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street			er, City or Town, State	a, Zip Code)
	alth all		Deborah K. Clatterbuck	PO T	30x 993 M	cHenry. M	D 2154	1	
Ē,	of Hez of Hez itam		20a. Method of Disposition	20b. Place of Disp cemetery, cr	position (Name of rematory or other place	e) !	Date	20c. Location - City	or Town, State
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Baltimore,	permit. Pa Depertmen Important: any injury phoe.		21. Signature of Funeral Service Licenses Ronald S. Wade, Dire	ctor	22. Name and Addre		treet	omy Roard Ralto Md	21201
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	per Dvr	nter the mode of dyin	g, such as cardiac	or respiratory er	rest,	Approximate Interval Between Onset and Death
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<u> </u>	or Att	튀	4 Homicide determined 28e. Place of Injury	y · At home, farm, s (Specify)	street, factory, office		City or Tou	Street and Number or vn, State)	Hural Houte Number,
_	To the Hospital or Attending Phywitin 24 hours after death. To the Funeral Director After this complataly filled in by the funeral	edicai Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of and manner state	xamination end/or i	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the o	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	ithin (ithin or the complant)	Med	29b. Signature and title of countries	- C.	29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
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			30. Name an 1 address of person who completed cause of dea	ith (Item 23a) (Tvo			1	avio.	
			A CONTRACTOR OF THE PARTY OF TH	1 N. 4th		and, MD	21550		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar		*				
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		•	For State Registrar		,		tificate					g. No. 200	6 17443
	Dhuaiai		1. Decedent's Name (First, Middle, L	ast)							Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Sherry Lyni							Ma	ay 17,	2006	3:00p M
F	Examin	er	4a. Facility Name (If not institution, g		oer)				Location o	of Death		4c. County of De	
			113 Stockton 5. Social Security Number 6.		. Age (In yrs. la	ast birthday)	E1	kto 1 Year	n If Under :	24 Hrs. 8.	Date of Birth	Ceci1	
	Funeral Director		222-52-6754	1 □ M 200 F	45		Months	Days	Hours	Min.Oct	Month, Day,	°10,1960	DE
	p.	ļ	Usual Residence of Decedent		10° Cit.	. Town or Lo							40d Inside City I imite
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	deatl	nera	11. Marital Status	12. Was Deced		S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Specify	Yes or No-	14. Race - Ar Black, Wi	nerican Indian,
36	or Its	by Fu	1 Married 2 Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 If Yes, Give	IX No	İ	1 ☐ Yes 2		Specify:		,,	Specify:	
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			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	th line.	. Do not ent			10477	- 10			Interval Between Onset and Death
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8760,	icate be executed physician and s the burial-transit		resulting in additity East	Due to (or	r as a consequ	ience or):							
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Vital		Φ	25. Was case referred to medical	T					26. Place	of Death (C	1 ☐ Yes 2 heck only one		es 2□No
Ž	is dil	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Inj	oatient 2 🗆 I	ER/Outpatier	it 3□ DO	A Othe	r: 4□Nu	rsing Home	5 Resider	nce 6 □Other (Sp	pecify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending		Injury Day Year)	28b. Time o Injury		Bc. Injury Work			. Describe how	v injury occurred	
Division	Attanding r death. sctor: After by the funer	ertification;	2 Accident investigat 3 Suicide 6 Could not	be 30- Blace	f Injury - At ho	me lam etr	M agt lactory		fes 2□f		Location (Str	eet and Number or	Rural Route Number,
Div	or Attand after death Diractor: ,	ertif	4 Homicide determine	building	g, etc. (Specify)	eet, ractory	, 011100			City or Town,		Tarar riodio rearios,
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in D	dical C	29a. Certifier 1 Certifying	hysician: To the b	est of my know	wledge, deat	occurred a	at the tim	e, date an	d place, and	due to the ca	use(s) and manner	as stated.
	tha Ho nin 24 tha Fu npletel	O I	one)	aminer: On the bas and manne		ion and/or in				in occurred a			
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	1	1		290	License	number	99	29	d. Date signed (Mo	
			- Vien'l	n N	of do-th //-	02a) (T	Print') 5	50	1.1		5/18/06	
			30. Name and address of person who	5 W. A	ligh	23a) (Type,	EIKH	an	no	719	721		
	Sta	te	31. Date filed (Month, Day, Year)	Ø 32. Re	gistrar's Signal	ture			1		, 7		
E	Regist	ar	MAY 1 9 2006	Blown	· D	Jane 1							

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ann COPLIN MAY 2006 09541 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner County General
oer 6. Sex 7. Age (In Hospita Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 03-23-1957 Director 214-68-7397 Maryland | Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Exampler must be notified at 1 Yes 2 No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21045 6145 Quiet Times USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status • filed within 72 hours after d. I Hygiene. other than "natural", or Item Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 USDA Food Inspector other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 Is marked ott Clarence Copeland Mary Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is any injury or other trau 418 Ball Park Road, Snow Hill, Maryland 21863 <u> Ann Broadwater / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Tindly's Chapel Cem 05-20-2006 Pocomoke, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Six plum / Fuceral Service Licens Bennie Smith Funeral Home 524 Race Street, Cambridge, Maryland 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, of heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ thrombocy topenion 1 Yes 2 No 3 Probably 4 Onknown Completed large right effusion 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending To the Hospitel or Attendir within 24 hours after death.
To the Funerel Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 142892 200G 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Columbia Little Paturent Francis Chuidian 10724 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For			Dep	artment of I	ealth and M	_		The state and	1744
		State Registrar			Ce	rtificate of	Death		Reg. No.		
Physicia		 Decedent's Name (First, Middle, Las 	•					2. Date of De Month	eath Day	Year	3. Time of Death
/Medica		Agnes Josephine						May		006	3:45 A
Examine	r	4a. Facility Name (If not institution, give				4b. City, Town,	or Location of Death		4c. Cou	inty of Death	
		St. Mary's Nursin 5. Social Security Number 6. S	<u> </u>	e (In yrs. last i	- Control of a co	Leonar		0 D-1(D:		Mary	
Funeral Director		217-30-0676	M 2∑xF	82	Yrs.	Months Days		8. Date of Bi (Month, Di Jan.	ay, Year) 3 1924		place (State or Foreig ntry) 71and
and wa	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or L	ocation					10d. Inside City Limits
or 28s-1 show	<u>ē</u>	Maryland St. Mary	's	Bush	พดด	đ					1 ☐ Yes 2 🖫 No
the 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
3a of		22650 Bushwood C	ity Road			20618			Unite	d Stat	0.5
after death w	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of I	Hispanic Origin? (Spe ban, Mexican, Puerto f	cify Yes or No	o- 14. F	Race - Ameri	can Indian,
	2	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑! If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No		rican, etc.)		Black, White, ec <i>ify:</i> B1	ack
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; any injury or other traumatic event, the Madical Eagonce.	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	a. Dece	edent's Usual Dccu	pation during most of working	ng	16b. Kind o	f Business/In	dustry
ne. han	ă.	Elementary/Secondary (0-12)	College (1-4or 5				during most of workir				
lied v lygie her t		17. Father's Name (First, Middle, Last)			Home	e Maker	18. Mother's Name	/First Middle	*	n Home	2
od of	Pe C									alle)	
d Me d Me mark matk	0	John Clement Dys 19a. Informant's Name/Relationship (10	h Mail	ing Address (Street	Mary Pea			um Stato 7i	o Codel
d 2 s th an trau trau		Linda C. Somervil					ive Ft. Wa		•		
Heal Heal	T	20a. Method of Disposition	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20b. Place	of Disp	osition (Name of	D	ate		on - City or T	
ages ant of it: If I		1 ☐XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific				matory or other pla eart Ceme		/2006	Ruchsz	ood V	aryland
ortan ortan injur	-	21. Signature of Funeral Service Licen		Dacte			ess of Facility Bri				
Depa Impo any i		Kyle S. Simon	1	much	- :	22955 Hol	lywood Rd.	Leona. Leona	rdtown	rai no . Marv	me PA. land 2065:
		23a. Part1. Enter the disease, or comphock, or heart failure. List only Immediate Cause (Final	olications that caused	I the death. D							Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	a. ASCUD Due to (or as	a consequenc	e of):						5years
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
nsit	Examiner	Cause (Disease or injury	220 10 (0. 0.0		0.7.						
be executed sician and burial-transit	Xar	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):						
bur bur	_		4 =								
ficate phy s the	edic		. d.								
The law requires that the death certificate b te has been signed by the ettending physic age 2 should be detached for use as the b	nysician/medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у			Date of delive Month	ery Day Year
that the the ded by detact	7.	Part II. Other significant conditions c	ontributing to death b	ut not resulting	in the	anderlying cause gr	ven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
uires n sign	d b	Dementia						1 🗆	Yes 2 X INo	3 Prol	pably 4 Unknown
w requir	ere							24a. Was	an 24	h Were auto	opsy findings available
The lavate has	Completed				-			auto perfe	opsy ormed?	prior to co death?	mpletion of cause of
	3	25. Was case referred to medical					26. Place of Death	Check only	XXNo	1 🗌 Yes	2 X No
ysician: us certifica director.	o	examiner? 1 ☐ Yes ②XXNo	Hospital:	ent 2 ER/O	Sutnatie	nt 3 DOA Ott	her: 4X Nursing Hon			Other (Speci	6.1
	-	27. Manner of Death	28a. Date of Inju (Month, Da		. Time				how injury occ		<i>y</i> /
ath. r: Aft	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		y rear)	Injury		Yes 2 No				
or Atternation of Atternation Director	3 Suicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							(Street and Nu wn, State)	mber or Rura	al Route Number,	
e i se e	edical C	29a. Certifier (Check only one) 1 X Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examination a	ge, dea and/or ir	th occurred at the to	me, date and place, a opinion, death occurre	nd due to the	cause(s) and date and place	manner as s	stated. the cause(s)
To the within To the comple	⊒ S	29b. Signature and title of certifier		41)	29c. Licens	se number		29d. Date/sig	ned (Month,	Day, Year)

State Registrar Leon Berube MD.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28170 Old Village Road, Mechanicsville, Maryland 20659

32. Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

D000506

		-	For Stete Registrar	State of Maryla	•	artment of H		-	giene Reg. No. 200	5 17447				
	Physici	an	1. Decedent's Name (First, Middle, La	1	-			2. Date of De.		3. Time of Death				
6	/Medic	al -	Darlene 4a. Facility Name (If not institution, giv	M. e street and number)	Fishel	4b. City, Town, or	Location of Dea	02	4c. County of De	O'AOS M				
1	Examin	er		trt Hospi	TAL	cum	BERL	AND	ALLE	GANY				
	Funeral Director		103-40-0013	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		5, 1951	inhplace (State or Foreign Country) MD				
	laryland ahow	20	Usual Residence of Decedent 10a. State 10b. County MD Allega		City, Town or Lo	nberland				10d. Inside City Limits 1 □¥es 2 □ No				
	with the Manager of the neutring	Direct	10e. Street and Number 390 Pine Avenue			10f. Zip Code	21502		10g. Citizen of What C	Country?				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "neturel', or Items 23a or 28e-f ahow any Injury or other traumatic event, the Medical Examinal must be multiled at ODGs.	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No- ino Rican, etc.)	14. Race - An Black, Wh	rerican Indian,				
2-00	72 hour	eted t	15. Decedent's E (Specify only highest gra	ducation	(Give	dent's Usual Occupa	turing most of w	orking	16b. Kind of Busines					
21215-0036	ad within rgiene. er then ', the Me	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired emaker			Own Hom	е				
Maryland	uld be file Mental Hy irked oth	To Be	17. Father's Name (First, Middle, Last Floyd Troutma					,	Maiden Surname) es) Troutma	an				
	ind 2 sho eith and ! 27 is ma		19a. Informant's Name/Relationship (Richard Fishel S	Type, Print) Sr. husband	19b. Maili 390	ng Address <i>(Street a</i>) Pine Ave	und Number or F NUE	Rural Route Numbe Cum	or, City or Town, State, berland	Zip Code) MD 21502				
Baltimore,	Pages 1 a ment of He ant: If Item ury or othe			8)	Date 6/1/2006	20c. Location - City of Cumberla								
Balt	permit. Departi Import. eny Inj		21. Signatore of Funeral Service Licensee 22. Name Staff Perilli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502											
			shock, or heart failure. List only	one cause on each line.				,	rest,	Approximate Interval Between Onset and Death				
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) The condition of the condi											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of):									
\$ 0928	cate be executed physicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):									
9289	icate be physicia the bu			d										
P.O. Box 6	thet the death certificed by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes, 2 No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year				
ds, P.	w requires that the been signed by the should be detache		Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.		obacco use contribute	to the cause of death?				
Division of Vital Records,	aw 2 st	Completed by						24a. Was	sy prior to	autopsy findings available ocompletion of cause of				
talF	Th ete pag	4	25. Was case referred to medical				26. Place of De		2 No 1 □Ye	s 2 No				
of Vi	S D	To B	examiner? 1 Yes 2 No		☐ ER/Outpatier		er: 4 🗆 Nursing	Home 5 ☐ Resid	lence 6 □Other (Sp	ecify)				
ono	ding P th. : After t	tlon:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	rat (? Yes 2 ∐No	28d. Describe h	now injury occurred					
Divis	or Atter after dea Director	Certification;	3 Suicide 6 Could not be determined		home, farm, str cify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,				
-	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 12 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the bast of my k miner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occ	ce, and due to the courred at the time,	cause(s) and manner a date and place, and du	as stated. re to the cause(s)				
	To the To the	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Mor					
	, :		1/1hm	7/2		1731	9010		May 36	12006				
	4		DR VIK COMO	completed cause of death (It	em 23a) (Type,	24 Sero	DR	ive Cur	nbezian	D'MD31203				
	Sta Registi		31. Date filed (Month, Day, Year)	2. Registrar's Sig	nature	de la								

DHMH 17 Prev 1/2001

06-03345 Please Type or Print in Black Indelible Ink James Richard Ferguson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 17, 2006 Medical Examiner 2117 hrs Richard Ferguson James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 9. Birthplace (State or Foreign Washington 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 1 X M 2 F Country) 213-42-8012 60 July 22, 1945 DC Usual Residence of Decedent uny 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show and Montal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho-matic event, the Medical Esaminer must be notified at once. Maryland St. Mary's Pages 1 and 2 should be filed within 72 hours after death with the Maryland Mechanics ville Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 30073 Shoreview Drive 20659 United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Carpet Installer Carpet 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ James W. Ferguson Ruth Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine A. Ferguson/Wife 30073 Shoreview Drive, Mechanicsville, MD 20659 of Health a 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department o Important: injury or oth 4 Donation 5 Other Specify: Oueen of Peace Cem. 5-22-2006 Helen, Maryland permit 22. Name and Address of Facility Brinsfield-Echols Funeral Home 21. Signature of Funeral Service Licenses m01206 30195 Three Notch Rd., Charlotte Hall, MD 20622 Kyle S. Simons 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED attending physician for use as the burial AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the atte 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed certificate has been rector, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? 1 Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural 1 Yes 2 No 5 Pending To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 KeV 17200

OCMF 2006

Assistant Medical Examiner

egistrar's Signati

30. Name and address of person who completed cause of death (Item 23a)

2 2006

Patricia Aronica-Pollak MD.

31. Date filed (Month, Pa

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 19, 2006

State of Maryland / Department of Health and Mental Hygiene 2005 7449 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death $\stackrel{\text{Month}}{\text{may}}$ 20, $\stackrel{\text{Day}}{\text{2006}}$ **Physician** Year Wanda Hope Fedor 11:26р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 30,1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Texas **Funeral** 1 □ M 2 🗸 F 578-38-5451 80 Yrs. Director Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's **Mechanicsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 27733 James Road 20659 USA Iteme 23a death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if Item 27 ie marked other than "natural; or Item eny Injury or other traumatic event, the Medical Exemptions. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 5-0036 1 ☐ Yes Z No Specify: þ 3 Widowed 4 ☐ Divorced Specify Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Secretary Aircraft Industry 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Peacock Haze1 Норе ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill A. Stauffer/Daughter 27733 James Rd., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols 5/23/2006 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols Funeral Home P.O. Box 128, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricular Arrhythmia /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physicien and the burial-transit The law requires that the death certificate be executed End Stage Renal Disease Due to (or as a consequence of): Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ٥ in the past 12 mort Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown been 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one To Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Mann 1 Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medicai Certification: 28d. Describe how injury occurred After Division 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel [the Hospitel pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely or: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maker stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D 55027 30. Name and address of pers of who completed cause of death (Item 23a) (Type, Print) 37767 Market Drive, Charlotte Hall, MD 20622 Manoj D. Panwala State 2006

DHMH 17 Rev 1/2001

Registrar

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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Menial Hydiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinational bancellist at ODGe.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	emetery, crei	nsition (Name o matory or other	place)	Date		_ocation - City or	
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		For State Registrar	State of Marylar			t of Hea e of De		Mental Hy	gienę Reg. No.		06		15
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2332 Hobell Bessie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
ALLEGAN 4b. City, Town, or Location of Death Examiner Backed Heart Hospital COMBERLAND If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Year) Sep 3, 1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** DWind 1 □ M 2 □ X Director <u>218-34-4414</u> 69 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow rthan "natural", or Itame 23a or 28e-f ahov the Medical Examinar must be notified at LaVale MD Allegany 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 11 Klosterman Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Specify: white \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 Is marked other then "s Elementary/Secondary (0-12) College (1-4or 5+) **Utilization Review** Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Estella Florence Swick Grover Lawson Ketterman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 11 Klosterman Avenue LaVale MD 21502 permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other trau husband Harry Hobell Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place Sunset Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/1/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name Scarpetti Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Probable Acute Myocirchial don /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Oulmonar cete has been signated by page 2 should b arrest 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificete has 2140 of Vital 1 ☐ Yes 2 ☐ 1√0 1 TYAS Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Hipatient 2 ☐ ER/Outpatient 3 ☐ DOA hours effer death. marel Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Injury 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospitel or within 24 hours effort To the Funerel Dil 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical c_mpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wampunam 056207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Drive

Combercan

900 SETON

M.D.

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

			1 - State Registrer	of Maryla	•	artment of F		d Mental Hyg	iene eg. No. 2006	17456
			Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Physici: /Medic			Do	uglas	Slater	Hafer	Month MAY	23, 2006	5:30 A M
	Examin		4a. Facility Name (If not institution, give street and n			4b. City, Town, o			4c. County of Death	1
		•	16307 MAPLEVIEW DRIVE,	SW		FROSTBU	JRG		ALLEGAN	ſΥ
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Birth Ain. (Month, Day,	9. Birth	place (State or Foreign intry)
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	p ,		Usual Residence of Decedent	10-0						
	aryla shov	_	10a. State 10b. County	100.0	ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f	octo	MD ALLEGANY		FROSTB	_				
	vith th	Funeral Director	10e. Street and Number	G14		10f. Zip Code		1	0g. Citizen of What Cou	intry?
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	er de Items	an a	Armed		J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin: an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White	
36	s aft	by F	1 Never Married 2 Married 1 Yes, 0 3 Widowed 4 Divorced Year or	2 X No Sive		1 ☐ Yes 2 🔀 No	Specify:		Specify: Til	HITE
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<u>a</u>	should be filed vind Mental Hygie is marked other t imatic event, the	To B	JOHN JACOB HAFER, JR.				SHI	ERRY FERN	SLATER	
Maryland	shound M		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route Number,	, City or Town, State, Zi	p Code)
Ž	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av once.		KRISTAN HAFER, WIFE		1630	07 MAPLEV	IEW DR	IVE, SW, FI	ROSTBURG, M	D 21532
ā,	s 1 a f Hea item othe		20a. Method of Disposition	ł	Place of Dispo	sition (Name of matory or other place	ا ام	Date	20c. Location - City or T	own, State
Ë	Page ent o nt: If ry or		1 \ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State FF		G MEM. PA	· 1	/30/2006	FROSTBURG,	MD
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	/Medical		disease or condition resulting in death) a	o (or as a conse		DKLIM	10	TRUK		144B
0	Examiner									
	-= ""	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a conse	quence of):					
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ó	an ar rial-ti	EX		o (or as a conse	quence of):					
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89	rtifica ng ph as th	Physician/Med	IF FEMALE:							
XOX	leath certific attending pl	an/h	23b. Was decedent pregnant 23c. If yes, o	utcome of pregr		Ectopic pregnancy			23d. Date of deliv	•
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	Physicia		Margaret Louise					Month	Day		12:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	May 1	_	2006 County of Deatl	
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and	M T		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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	ems Et Ta	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (San, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White	ncan Indian,
s afte	o la	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:				ite
within 72 hours after	tural'		3 X Vidowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occup	nation		16h Kir	md of Business/I	
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aryland should be file	Mental arked o	To	William Dent Hayo	len			Lillian	Agnes Fo	ord		
2 5	10 6		19a. Informant's Name/Relationship (T)			ng Address (Street					ip Code)
6, 5 1 and	lealth om 27 ther tr		Carol A. Nichalson /			Box 222, G		Maryland Date		t cation - City or	Town State
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Geath certifica	endin r use	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnancy	,		2	3d. Date of deli	,
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Hospitel or Attending Physician:	within 24 hours after To the Funeral Directorpletely filled in b		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge deat	h occurred at the tir	Tie, date and place	and due to the	cause/e)	and manner as	stated
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) =	withir To th comp.	Me	29b. Signature and title of certifier	a.l.		29c. Licens		_	-	signed (Month	
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			30. Name and address of person who c								
	win.		A.D. Shah, M.D. St.	Mary's Medical A		ding, Leon	ardtown, Ma	ryland 200	550		
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			For State Registrer	State of Maryla				lealth an Death			Reg. No	006		58
e i	Physici /Medic		1. Decedent's Name (First, Middle, Last) Arlene Margaret H			11. 03	·		0	Date of Dea Month 05/16/2	2006	Year	3. Time of 0	Death A ^M
1 100 A	Examin	er	4a. Fecility Name (If not institution, give s Howard County Gene		1	1	, Town, or umbia	Location of D	Death			county of Death ward	1	
	uneral irector		501-40-9366	7. Age (In yrs	i. /ast birthday) 5 Yrs.	If Unde Months	Days	If Under 24 Hours	Min	Date of Birt (Month, Da)3/10/	h y, Year) 1941	Co	pplace (State or untry) th Dakot	
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within 72 hours after death with the Maryland	d other then "naturel", or Itema 23a or 28e-f ehow event, the Medical Examinat must be routified at	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Dece If Yes, spe 1 Yes		ispanic Origin In, Mexican, F Specify:	n? (Specifi Puerto Ric	fy Yes or No- can, etc.)		4. Race - Ame Black, White Specify: Wh:		
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Mary nd 2 shou lith and M	27 le mar r traumat	-	19a. Informant's Name/Relationship (Type Gary Lee Hicks/ Hu	oe, Print)		•		and Number of				Town, State, Z	ip Code)	
Baltimore, Department of Hea	Important: If Item 27 le marked eny injury or other traumatic evonce.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	20b. emoval from State	Place of Dispo cemetery, cre untt Cr	osition (Na matory or	ame of other plac	(8)	Date	θ	20c. Loca	ation - City or		
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Tot	Tot	Σ	29b. Signature and title of certifier	4 Dh	, u		9c. Licensi 141248					signed (Month		
			30. Name of address of person who co George I. Okang, M	D 5755 Ceda	r Lane		mbia	, MD 2	1044					
	Sta Registr		31. Date filed (Month, Day, Year) MAY 18 200	6 Registrar's Sign	nature	will !								

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hysici		Georgene B. Holla	and			May 11,	2006 Year	4:45 P N
/Medic xamir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or L	ocation of Death		4c. County of Death	
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neral ector			7. Age (In yrs. last b	rthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) March 16	9. Birthp Count 5, 1915Czec	lace (State or Foreig htry) hoslavaki
		Usual Residence of Decedent 10a. State 10b. County	10c, City, Toy	wn or Location			1	0d. Inside City Limit
	5	MD	Baltir				,	1,□Yes 2□N
- B	ect	10e. Street and Number	Dalti	10f. Zip Code		100	g. Citizen of What Cour	
5 3		427 N. Curley St		21224	4		USA	,
SHE SHE	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cuban,		cify Yes or No-	14. Race - Americ	
event, the Medical Examinational be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		Mexican, Puerto F Specify:	Rican, etc.)	Black, White, Specify: Wh	^{etc.} ite
Medical 1	pleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation 16: de completed) College (1-4or 5+)	a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)	ion ring most of workir	ng 16	6b. Kind of Business/Inc	dustry
	Eo	8	College (1-401 5+)	Homemaker			Own Hom	e
vent,	Bec	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, Ma	siden Surname)	
tic e	ToE	Anthony Blazek			Anna	Unk		
in rem z/ is marked other then or other treumatic event, the M		19a. Informant's Name/Relationship (<i>T</i> Thomas Holland		b. Mailing Address (Street an Ol Washington				
othe		20a. Method of Disposition	20b. Place	of Disposition (Name of ery, crematory or other place)	D	ate 20	c. Location - City or To	wn, State
ry or		MSBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	nemoval mom state	awn Cemetery	5-15-	-06 E	Baltimore,	MD
Importent: If Rem 27 any injury or other tr <u>once</u> .		21. Signature of Funeral Service Licente	See	22 Name and Address Fink Funera		P.A.		0.4440
		K. Gregory Fin		426 Crain F	Hwy S. G1	en Burni	e, MD 210	
ician dical		23a. Part1. Enter the dishese, or ubmeshock, or heart failure. List of the sistence of the disease or condition resulting in death)	a	the fleat	- Fail	u	,	Approximate Interval Between Onset and Death
niner	L		b. Due to (or as a consequence	9 OI).				
	9	Sequentially list conditions,		of.				
transit	aml	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	c					
nysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	o of):			23d. Date of delive Month	ory Day Year
by the attending physician and ached for use as the burial-transit	cal	IF FEMALE: 23b. Was decedent pregnant	c	h 3 ⊟Ectopic pregnancy			1	,
d by the	by Physician/MedIcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	c	h 3 □Ectopic pregnancy 5 □ Other (specify)	in Part I.		1	Day Year
been signed by the hould be detached	by Physician/MedIcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	h 3 □Ectopic pregnancy 5 □ Other (specify)	in Part I.		Month cco use contribute to th 2 □ No 3 □ Prob	Day Year le cause of death? abiy 4 Munknown
as been signed by the 2 should be detached	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	c	h 3 □Ectopic pregnancy 5 □ Other (specify) in the underlying cause given		1 Yes 24a. Was an autopsy performe 1 Yes 2	Month cco use contribute to th 2 □ No 3 □ Prob 24b. Were autoprior to corr death?	Day Year le cause of death? ably 4 MUnknown
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Arter mis certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by Physician/MedIcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a consequence of 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown Description of the set of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	h 3 Ectopic pregnancy 5 Other (specify) in the underlying cause given n outpatient 3 DOA Time of 28c. Injury & Work? M 1 Ye farm, street, factory, office	26. Place of Death 4 Virursing Hon at 2 as 2 \(\text{No} \) 2 date and place, a anion, death occurre	1 Yes 24a. Was an autopsy performs 1 Yes 2 (Check only one) ne 5 Resident 8d. Describe how 8f. Location (Stre City or Town, nd due to the cau do at the time, date	Month CCO use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contrib	Day Year Day Year Day Year Day Year Day A Sunknown Day A Sunknown Day Indings available inpletion of cause of au
Inis certificate has been signed by the al director, page 2 should be detached	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of Due to (or as a consequence of	h 3 Ectopic pregnancy 5 Other (specify) in the underlying cause given n outpatient 3 DOA Time of 28c. Injury a Work? M 1 Ye farm, street, factory, office	26. Place of Death 4 ye ursing Hon at 2 es 2 No 2 date and place, a nion, death occurre	1 Yes 24a. Was an autopsy performs 1 Yes 2 (Check only one) ne 5 Resident 8d. Describe how 8f. Location (Stre City or Town, nd due to the cau do at the time, date	Month 2 No 3 Prob 24b. Were autor prior to cordeath? 2No 1 Yes ce 6 Other (Specify injury occurred et and Number or Rura State) se(s) and manner as state and place, and due to	Day Year Day Year Day Year Day Year Day Year Day A Sulphnown Day findings available Inpletion of cause of 2 No No No No Route Number, ated. the cause(s)

			1 - For State Registrar		State of	Maryla	nd / Depa		t of H	ealth a	and M	lental Hyg	-	06	17460		
	Dh		Decedent's Name (First, M.	liddle, Las	t)							2. Date of Dea	ath		3. Time of Death		
	Physici /Medi			Nel	1 E.	Imler						Month MAY 20	Day 2006	Year	12:25P. M		
	Examir		4a. Facility Name (If not instit	ution, give	street and num	ber)		4b. City,	Town, or	Location o	of Death		4c. County	of Death			
			Memorial Hos	nita	I			Cumb	erla	ınd			A	llega	anv		
	Funeral	0	5. Social Security Number	6. Se	x 7	-	. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth	h Vaari	9 Birth	nlace (State or Foreign		
	Director		192-18-7398		M 2XXF	96	Yrs.	IVIOTICIS	Days	riours	TVIII I.	Hrs. 8. Date of Birth Min. 6-16-1909 9. Birthplace (State or Fore					
	pu k		Usual Residence of Decedent 10a. State 10b. Co.			100 0	ity, Town or Lo	netion.									
	sho	5		•	y Co.		umberla								10d. Inside City Limits 1 X Yes 2 □ No		
	he M	ect	10e. Street and Number	Legan	у со.												
	with	ā	10301 Christ:	o Da	NIE			10f. Zip					10g. Citizen of	What Cou	intry?		
	72 hours after death with the Maryland Insture!', or Iteme 23e or 28e-f show dital Examiner must be notified at	Funeral Director		Le Ku		le et Constalle	10 10		1502				USA				
	ler de ner	Ë	11. Marital Status	Marriad	12. Was Deced	es?	J.S. 13. 1	f Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Amer ck, White	ican Indian, , etc.		
36	rs aft		Never Married 2☐ 3☐ Widowed 4☐ Divo		1 Tes 2 If Yes, Give Year or Dat	1		1 🗆 Yes 💈	2 🙀 No	Specify:			Specif	y: Whi	te		
Ş	hou	Completed by		dent's Ed			16a. Deced	fent's Lieuz	d Occupa	tion			16h Kind of B	uning and	aduat-		
15	in 72	piet	(Specify only hi	ghest grad	le completed)		(Give	kind of wor	rk done d se retired	uring most	of worki	ng	16b. Kind of B	12111622/11	idustry		
212	filed within Hygiene. Ither then "	шо	Elementary/Secondary (0-	2)	College (1-4 4	4or 5+)		1001 T					Public	Sch	ools		
ğ		Bec	17. Father's Name (First, Mid	dle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Suman	ne)			
<u>a</u>		To B	Benj	jamin	Imler						Elsi	e Poor	baugh				
Maryland 21215-0036	\$ 5 E E	Γ.	19a. Informant's Name/Relat	onship (T	ype, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	r, City or Town,	State, Zi	o Code)		
	alth a alth a 27 io	6 8	Patricia	Pau	gh		2198	Belle	emont	e Ct	. J	efferso	n. MD 2	1755			
J.	of Healt Item 2	1	20a. Method of Disposition				Place of Dispo cemetery, cren	sition (Nam	ne of			- 1	20c. Location -		own, State		
Ē	Pages nent of I ant: If Ite		1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe				ion Cen				-23-	2006 M	eversda	le.	PA 15552		
Baltimore,	교육관금 .		21. Signature of Funeral Sen		24										ome, Inc.		
m	Depermine Perm		1/1/Illian	$\neg X$	Truis	CC	0376 3	325 Ma	ain S	St 1	Meve	rsdale,	PA 155	52	onic, The.		
			23a. Part1. Enter the disease shock, or heart failure.	, or comp	ications that car	used the dea									Approximate		
	Physician		Immediate Cause (Final	LIST OTHY O	ile cause on ear	ai iiie.	Dn		^	4.					Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)		a Due to (o	r as a consec		em	1001	9					5 days		
	Examiner				·									İ			
		ner	Sequentially list conditions,	•	Due to (or	r asi a contrac	quenes off;										
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	e												
oʻ	te be executed ysicien and te burial-transit		resulting in death) Last		Due to (or	r as a consec	quence of):										
		ical			d												
39	death certifica e ettending ph id for use as th	Med	IF FEMALE:														
Вох	leath certific ettending p	an/	23b. Was decedent pregnant	2	3c. If yes, outco	me of pregn		Ectopic pre	annancy				23d. Dat	e of delive	ery		
		sici	in the past 12 months? 1 □ Yes 2 ☑ No			nt at time of o		Other (spe					Mo	nth	Day Year		
P.O.	The law requires that the de ste hes been signed by the e page 2 should be detached f	Physician/Med	9 Unknown														
Ś	w requires that been signed to should be det	by	Part II. Other significant con-	litions co	ntributing to dea	th but not res	sulting in the un	iderlying ca	luse give	n in Part I.		23e. Did tol	acco use conti	ibute to t	ne cause of death?		
Records,	s nee	ted										1 🗆 Ye	s 2 No	3 Prob	bably 4 🗹 Unknown		
ec	law les b	ple									_	24a. Was a autops	n 24b. V	Vere auto	psy findings available mpletion of cause of		
<u>ж</u>		Completed										perform	negy c	leath?			
/ita	Physician: r this certific ral director,	Be	25. Was case referred to med examiner?	ical						26. Place	of Death	Check only on					
Ž	hysi his o	၉	1 ☐ Yes 2 Ø No	1	fospital:	atient 2	ER/Outpatient	3 DO	A Other	4 □ Nur	sing Hon	ne 5 🗆 Reside	nce 6 Othe	er (Specit	y)		
u	ng P fter t inera	ë	27. Manner of Death 1 ☑ Natural 5 ☐ Per	ndina	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	Bc. Injury	at	2	8d. Describe ho	w injury occurr	ad			
Sio	Attending r death. ector: After by the fune	cati	2 Accident inve	stigation				М	1 🗆 Y	es 2□N	lo						
Division of Vital	or At after d Direct in by	Certification:		ermined	28e. Place of building	f Injury - At h , etc. <i>(Specil</i>	ome, farm, stre	et, factory,	office		2	8f. Location (St. City or Town	reet and Number, State)	ar or Rura	l Route Number,		
	urs a				,	1											
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	CHOCK ONLY Z MEGI	ying Phy al Exami	sician: To the bener: On the basi	is of/examina	owledge, death ation and/or inv	occurred a estigation.	it the time in my opi	, date and nion, death	place, a	nd due to the ca d at the time, da	use(s) and ma	nner as st	ated.		
	the the mplet	Med	3.10)	1	and manne	r stated.											
	5 ¥ 5 2	_	29b. Signature and title of cer	/ /	. //		-		License 36			29	d. Date signed				
~75				11.0	4/				שועיע	100			1200	122	5006		
		- 1	30. Name and address of pers	on who co	mpleted cause	of death (Iten	Δ.	1 1	4		1						
			31. Date filed (Month, Day, Ye	42	4 Jetor	Drive		iberto	ind.	Ma	410	nd 215	02_				
	Sta Registra			ar) 262		istrar's Signa	uure 4	A									
		11	MAI	N U L	.000	Magner o		Towns of the	g								

			1 - State of Management		artment of Hea			2006	17461		
			Registrar 1. Decedent's Name (First, Middle, Last)	Oe,	tincate of be		Reg. I	No 0 0 0	3. Time of Death		
	Physicia		Boyd Solon Johnson					2006	2:30 P M		
	/Medid Examin		4e. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of Death			
	LXamiii		Oakland Nursing & Rehab Ce	nter	0 a kl a n			Garrett			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Ag	e (In yrs. last birthday) 51 Yrs.		Under 24 Hrs. 8. [lours Min. M	Date of Birth Month, Day, Yea	(ear) 9. Birthplace (State or Foreign Country) 1955 Maryland			
			Usual Residence of Decedent								
	rylan thow		10a. State 10b. County	10c. City, Town or Lo				11	0d. Inside City Limits		
	Ba-f s	cto	MD Garrett	Mounta	in Lake Par	:K			1 X Yes 2 No		
	with the a or 2	Director	10e. Street and Number		10f. Zip Code 215	50	10g. (Citizen of What Coun USA	try?		
	ns 23	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispar if Yes, specify Cuban, M	nic Origin? (Specify	Yes or No-	14. Race - Americ			
36	i within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-f show the Medical Exacultat must be notified at	by Fur	1 Never Married 2 Married 1 Yes 2 Named Forces? 3 Widowed 4 Divorced Year or Dates:	No		pecify:	in, etc.)	Black, White, o	nic. hite		
9	tural		15. Decedent's Education	16a. Dece	dent's Usual Occupation	1	16b.	Kind of Business/Inc	dustry		
15	in 72 in "nat	plet	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4ors	life.	kind of work done durin DO NOT use retired)	ng most of working					
21215-0036		Completed	6'th		aborer			ultry Prod	essing		
Maryland	ad la b	To Be	17. Father's Name (First, Middle, Last) Unknown	Jo	hnson 18.	Mother's Name (Fill Unknown			nknown		
ary	pi i	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and I						
	and 2 eaith a m 27 is		Scott Ward/Health Care Age		1, Box 68A3		-				
ore	of H of H ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other place)	Date		Location - City or To			
Baltimore,	permit. Pag Department Importent: any injury once.		'4 □ Donation 5 □ Other (Specify)	Oakland	Cemetery 2. Name and Address of	5/23/0		akland, Ma	rryrand		
Bal	permit. Pag Department Importent: any injury c		21. Signature of Funeral Service License		tewart Fune		0akland	econd St., MD 2155	50		
			23a. Part1. Enter the disease or complications that cause shock, or heart failure. List only one cause on each I	the death. Do not ent	ter the mode of dying, su	uch as cardiac or re	spiratory arrest,	^	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	te my	cardia	linta	retion) 1	1. Nutes		
	/Medical Examiner		Due to (or as	a consequence of).	TO	1000			20.1000		
Ь		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):	mery	u sem		0	e years		
	uted d ansit	Examine	cause. Enter Undertying Cause (Disease or injury that initiated events	extense	en)			ó	Oyears		
ó	be executed sician and burial-transit		resulting in death) Last Due to Gras	a consequence of):	1 —			3	1		
8760	ate hy:	dlcal	d. ala	betes 7	ype !			×	o years		
9	eath certific attending p I for use as	/Mec	IF FEMALE: 23c. If yes, outcome	of pregnancy				02d Date of deliver			
Box	attend for us	Physiclan/Me	in the past 12 months?	2 Fetal death 3	∃Ectopic pregnancy ∃ Other (specify)			23d. Date of delive Month	Day Year		
o.	at the de by the a	ysi	1 Yes 2 No 9 Unknown								
σ,	The law requires that the ate has been signed by the bage 2 should be detache	by PI	Part II. Other significant conditions contributing to death	out not resulting in the u	inderlying cause given in	Part I.	23e. Did tobacc	o use contribute to th	e cause of death?		
ords	v require been sig should b		Chronic heual faille	le on de	ialyees		1 🗆 Yes	2 No 3 Prob	ably 4 □Unknown		
of Vital Records,	e law requ has been je 2 shoul	Completed	U		V		24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of		
H		Con					performed 1 ☐ Yes 2 ☐	? death? No 1 ☐ Yes	2□ No		
/ita	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?		26. Other:	. Place of Death (Cl					
of	Physicien: this certific ral director,	L.	1 ☐ Yes 2 No 1 ☐ Inpati 27. Manner of D ath 28a. Date of Inji		nt 3 DOA	4.	5 Residence Describe how in	6 □Other (Specify	")		
	ling After fune	tlon	1 Natural 5 Pending (Month, Da	y Year) Injury	Work?	2 🗆 No		,,,			
Division	f or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of In	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	28f.	Location (Street City or Town, St	and Number or Rura ate)	l Route Number,		
	To the Hospitel or within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 ★ Certifying Physician: To the best	of my knowledge, deat	h occurred at the time, d	date and place, and	due to the cause	e(s) and manner as st	ated.		
	To the Hospitel within 24 hours: To the Funeral completely filled	edical	(Check only 2 Medicel Examiner: On the basis one) and manners	of examination and/or in	vestigation, in my opinio	on, death occurred a	it the time, date a	and place, and due to	the cause(s)		
	To the To the comp	×	29b. Signative and title of certifier	-	29c. License nu	mber	29d. I	Date signed (Month, I	Day, Year)		
			Margaret affect	n ND	D26	000	5/	22/2001	6		
			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	L 11. D.		ahland	md		
	j. j. 0.		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	1 yurett	trans	ay, o	unand	(21557)		
•	Sta Regist	ate rar	MAY 2 3 2006	me de de	E-10x25E				0.0,0		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Dylan Thomas Ki	1	- For State	State of	Maryland		tment o	f Health ar f Death	nd Menta	al Hygi		eg No	200	16 1746		
Physicia		Registrar 1. Decedent's Name	e (First, Middle,Last)							ate of Deat	h		3. Time of Death		
Medical Examir		Dylar	n Thomas Kn	otts					M	/lonth lay 25, 20	Day 006	Year	0917 hrs		
· Control of the cont		,	f not institution, give str Memorial Hospit		er)	Ĩ	4b. City, Town, o Cumberlan		Death			ounty of Deat	h		
Funeral			lumbern/a 6 Sex		Age (In yrs. las	st birthday)	If Under 1 Ye	ar If Under	24Hrs. 8.	Date of Birt	th (MM/DD		rthplace (State or		
Director			1 X M	2 F		Yrs	Months Day		Min 1	l-12-2006 Foreign Country) MD					
742		Usual Residence of			140- 04- 7					10d Inside City Limits					
w all		10a State	10b. County			Town or Loca							1 Yes 2 No		
yland 1-f sho	핡	WV 10e. Street and Nu	Mineral		Carp	oendale	10f. Zip Code			110	Da. Citizer	n of What Cou			
e Mar or 28:	Director							2			-9		,		
with the s 23a s 23a		11 Marital Status	ntucky Aven	ue Was Decede	nt Ever in U.S		2675 as Decedent of H	spanic Origin			- 14	USA Race - Amer White, etc.	rican Indian, Black,		
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	1 XNever Marrie	ed 2 Married	Armed Force Yes	s? 2 X No	If Y	es, specify Cuba	in, Mexican, I	Puerto Rica	an, etc.)					
after (by F	3 Widowed	4 Divorced If Y	es, Give Year Dates.		1	Yes 2X N					ecify whi			
hours natur		15. Decedent's Ed	ducation (Specify only h	ghest grade of College (1-4 of			nt's Usual Occupa nost of working life			done	16b. Kını	d of Business	/Industry		
36 vin 72 tian "dical	plet	Elementary/Seco	ondary (U-12)	College (1-4 c	01 5+)	т	n/a					n/a			
21215-0036 uld be filed within 7 Mental Hygiere marked other than	Completed		(First, Middle, Last)					18.Mother's	Name (Fire	st, Middle, M	Maiden Su				
215 be file ntal H rked c	Be	Ste	phen Knotts							Thoma					
hould hould is ma	유[ame/Relationship (Type				g Address (Stre								
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygere Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Stephen 1 20a Method of Dis	Knotts/fath	er	20b. P		Kentuck			penda		VV 26/5 cation - City o			
Baltimore, permit Pages I an Department of Hee Important: If ite			Cremation 3	Removal from	State Cr	rematory or o	ther place)		- 100 1	0006			3.50		
timent representations of the contraction of the contractions of the contractions of the contractions of t	ŀ		Other Specify: ineral Service Lycenses		GLe	ndale	Cemetery Name and Addres		5/28/2 Saars		Funci	ntston	e, MD		
Ba permi		//////	MIN	M	1		8 Virgi								
Physician		23a. Fart I. Enter th	ne disease, or complications one cause on each I	ions that cause	ed the death.								Approximate Interval Between Onset and		
/Medical Examiner		[Immediate Cause ((Final disease a S	udden in	fant dea	th synd	rame					·-···	Death		
ÇAdımıcı		or condition resulti	ng in death) Due	to (or as a cor	nsequence of).									
No company of	e	Sequentially list co		to (or as a cor	s a consequence of):										
	Examiner	(Disease or injury	that initiated	ed C.											
arted d ansit		events resulting in death) Last Due to (or as a consequence or). d.													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical	X UNPENDED	DED AMENDED item#23a,27,perME,g856,6/30/06 TT												
760, cate be physici the buri		IF FEMALE: 23b Was decedent	pregnant in the	3c If yes, outo				<u></u>				Date of deliver			
Box 6876(e death certificate the attending phy ed for use as the U	ल	past 12 month		Live birth Pregnant	at time of dea	ath	etal death 3 Other (Specify)	Ectopic	pregnancy		M	onth	Day Year		
Box e death the atte	ysici	1 Yes 2	No 9 Unknown	Unknown			((lei (Opcon))								
o. hat the ed by t	by Phy	Part II. Other sign	ificant conditions co	ntributing to de	eath but not re	sulting in the	underlying cause	given in Par	t I.				the cause of death?		
S, P.C uires that n signed Id be dete			<u> </u>						_				bably 4 Unknown		
of Vital Records, g Physician: The law require After this certificate has been si meral director, page 2 should t	Completed									24a. Was autop			utopsy findings available completion of cause of		
ital Recolician: The law	Com							_		1 Yes		1 🗸 Y	es 2 No		
tal Rection: The certificate ector, page	Be (25 Was case reference examiner?		oital: 1 long		5510		Other ₄			Desidence	- 0 - 0			
fVi Physi er this	To	1 Yes 27 Manner of Dea	2 No	28a Date of I		ER/Outpatier 28b Time of		jury at Work?	Nursing Ho	Describe	Residence how injury		er. 		
on of inding Ph	ion:	1 X Natural	5 Pending	(Month, Da	y.Year)			Yes 2							
Division tal or Attendi rs after death al Director: A	icat	2 Accident 3 Suicide	investigation 6 Could not be	28e. Place of	f Injury - At ho	me, farm stre	eet, factory, office	building, etc	. 28f			Number or R	ural Route Number, City		
Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 4 Homicide	determined	(Specify)						or Town, S	State)				
Division To the Hospital or Attent within 24 hours after death Tin the Funeral Director: completely filled in by the		29a Certifier (Check only	Certifying Physician:	To the best of	f my knowledg	ge, death occi	urred at the time,	date and place	ce, and due	to the caus	se(s) and r	manner as sta	irted		
To the How within 24 h In the Fui	Medical	- 01.		the basis of e d manner state	examination ar ed	nd/or investig			curred at the	e time, date					
	Σ	29b Signature and	d title of certifier	000				nse number				ite signed (Mi 26, 2006	onth, Day, Year)		
		a	MOCH	ulle	au do ath	232)	0.0				ay 2	-5, 2000			
		30 Name and add	ress of person who com , MD Assistant	Medical Ex			Street, Baltir	more, MD	21201						
	ate	31 Date filed (Mor		32. Regis	strar's Signatu	re Anaca	5								
Regis	trar	JUN	U & ZUU0	La Prince	- Dia	7									

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State		rtment of Health and tificate of Death	20	06 17463
Blooming	Decedent's Name (First, Middle, Last)	0011		2. Dete of Death Month Dey	3. Time of Death
Physician /Medical	Catherine Lordan			May 30, 2006	7:20 A.M.
Examiner	4e Fecility Neme (If not institution, give street end		4b. City, Town, or		y of Deeth
	St. Vincent Care Cent 5. Social Security Number 6. Sex	7. Age (In yrs. lest birthday)	Emmitsb If Under 1 Year If Under 24 Hrs	8 Date of Birth	derick 9. Birthplace (State or Foreign
Funeral Director	214-54-5752 Usual Residence of Decedent		Months Days Hours Min.		Pennsylvania
/land	10a. Stete 10b. County	10c. City, Town or Loc	ation		10d. Inside City Limits
Many Many Many Many Many Many Ctor	MD Frederick	Emmitsbu	ırg		1 √ Yes 2 □ No
5 ifter death with the Mar ritems 23s or 28s-f si interment be notified Funeral Director	10e. Street end Number		10f. Zip Code	10g. Citizen of	Whet Country?
ath w	· 335 South Seton Avenu		21727	U.S.	
ter de	Arme	Decedent Ever in U,S. 13. W d Forces? If	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	ce - American Indian, ack, White, etc.
036 urs af al', or by F	3 ☐ Widowed 4 ☐ Divorced Year	es 2☑No , Give 1 or Dates:	☐ Yes 2 No Specify:	Speci	ty: White
5-0 72 ho naturi	15. Decedent's Education (Specify only highest grade complete	16a. Decede	ent's Usuel Occupation	16b. Kind of E	WIII CE
Maryland 21215-0036 42 should be filed within 72 hours after death with the Maryland th end Menlel Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exerciner must be notified at	Elementery/Secondary (0-12) Colleg)e (1-40r5+)	ind of work done during most of wo. O NOT use retired)		ous Community
d 21 filed v Hygler th ent. In	17. Father's Neme (First, Middle, Lest)	lege 4 Chi	ild Care	Daught me (First, Middle, Maiden Suma	ers of Charity
yland yland build be fil Mentel H srked off srked off	Joseph C. Lordan			Curran	me)
aryla should and Men marke umartic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street end Number or Re		n, State, Zip Code)
end 2 saith er n 27 is	Sister Camilla Haran	t 333 S	S. Seton Avenue.	Emmitsburg, MD	21727
of He m	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal fr	20b. Place of Dispos			- City or Town, State
Limor Pages ment of lant: If lk	4 ☐ Donation 5 ☐ Other (Specify)	ST. JOSEP	H'S P.H. 6/2	/2006 EMMITSE	BURG, MD 21727
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantel Hyglene. Important: if Item 27 is marked other than 'natural', or items 23e or 28e-f show any Injury or other traumatic event, the Medical Evariner must be notified at once. To Be Completed by Funeral Director	21. Signature of Juneral Service Licensee	(.//	Name and Address of Facility 10 W. MAIN ST.,	SKILES FUNERA EMMITSBURG. MD.	
	23a. Part1 Enter the disease, or complications the shock, or heart failure. List only one cause				Approximate
Physician	shock, or heart failure. List only one cause	A L A		Λ	Interval Between Onset and Death
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	elateral Vn	lumonia	and	6 days
niner niner	b	Due to (or as a consequ	Heart Fai	lun acus	to 2days
68760, itilitate be executed g physicien end es the buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or mijury that initiated events	Oule to (or es e consequ	ence of):	and Chia	ve Oyeans
68760, ifficate be ey g physicien es the burie	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):		
	d				
O. E e deat he att ned for sicit	Part II. Other significant conditions contributing t	o death but not resulting in the und	derlying cause given in Part I.	23b. Did tobacco use co	entribute to the cause of death?
requires that the death certification is the attending thould be detached for use extend by Physician/Me				1 ☐ Yes 2 🖾 No	3 Probably 4 Unknown
Ord requir een s hould				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
The law ate has b page 2 si				1□ Yes 2(ŽÍNo	of death?
Of VItal Re Physician: The la riblis certificate has sel director, page 2 1: To Be Comp	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	1 ☐ Yes 2 ☐ No
Of VITal Physician: rithis certific rel director,	examiner? 1 ☐ Yes 2 ☒ No Hospital:	☐ Inpatient 2 ☐ ER/Outpatient	Other:	lome 5 ☐ Residence 6 ☐ Oth	ner (Specify)
Attending Professional Control of the funeral by the funeral iffication:	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	ate of Injury flonth, Dey Year) 28b. Time of Injury	28c. Injury et Work? M 1 Yes 2 No	28d. Describe how injury occur	rred
DIVISION C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pl	ace of Injury - At home, ferm, stree illding, etc. (Specify)	et, factory, office	28f. Location (Street and Numb City or Town, Stete)	ber or Rural Route Number,
Hospi 4 hou Funer tely fill	(Check only 2 Medical Examiner: On the	the best of my knowledge, death of the basis of examinetion and/or inventance stated.	occurred at the time, date end place stigetion, in my opinion, death occu	, and due to the cause(s) and morred et the time, date and place,	anner as steted. end due to the cause(s)
To the I within 2 To the I comple	29b. Signature end title of certifie	Aughli	29c. Ligense number		od (Month, Day, Year)
1	30. Name and address of person who completed of	ause of death (Item 23e) (Type, Pi	1 010 /0_) MAY 30,	, 2006
· ·	ALAN CARROLL, M.D. 3		, EMMITSBURG, MD	. 21727	
State Registrar	31. Dete filed (Month, Day, Year) JUN 0 2 2005	Registrer's Signature			
DHMH 16 Rev 6/95			INAL		

r loade Type of T	The mediate machine and a second	. Обраба		-
State of	Maryland / Department of Health and N	lental Hygid	ene	
ror State Registrar	Maryland / Department of Health and N Certificate of Death	Reg	1. No.2 U U I	0 1/461
cedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Hazel Mae Lee		MONTH	17th 200	6 8:30P M

Examine

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, it a Madical Experiment ast be notified at once.

Baltimore, Maryland 21215-0036 Pnysician /Medical

Hazel Lec

Division of Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 3

4a. Facility Name (If not institution, give	street and number)	7 –	4b. City, Town, o	Location of Death	1	4c. County	y of Death	
5. Social Security	Number 6. Sex	7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Year	9. Birthplace (Sta	te or Foreign
305-24- Usual Residence	9481]M 2□ X F	90 Yrs.	Months Days	Hours Min.	(Month, Day, Jovembel		915 WV	•
10a. State	10b. County		10c. City, Town or	Location				10d. Insid	e City Limits
MD	Harfor	đ	Be1cam	p				1 🗇	Yes 2X No
10e. Street and Nu	ımber			10f. Zip Code		1	0g. Citizen of	What Country?	
1123	Belcamp	Garth		21017			U.S.A	A .	
11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S. 13	3. Was Decedent of H	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)		ce - American India	n,
1 ☐ Never Mar 3 😾 Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:			Specify:			w White	
(Spe	15. Decedent's Edu cify only highest grade	cation e <i>completed)</i>	16a. Dec	cedent's Usual Occup ve kind of work done b. DO NOT use retired	ation during most of wor	rking	16b. Kind of B	Business/Industry	
Elementary/Sec	ondary (0-12)	College (1-4or 5	+)	ousewife			House	eho1d	
	(First, Middle, Last)			Oubewill C		ne (First, Middle, I	Maiden Sumai	me)	
	Muncey			Adjust January	Vida W	Valker			
	Name/Relationship (Ty	rpe, Print)	19b. Ma	ailing Address (Street	and Number or Ru	ıral Route Number	r, City or Town	, State, Zip Code)	
	ncan/Son		40	Middle	Rd., E1	kton, l	MD 21	1921	
20a. Method of Di	sposition			sposition (Name of rematory or other place				- City or Town, Stat	е
° 4 □ Donation	Cremation 3 F			Cemeter	у Мау 2	24,2006	E1kt	on, MD	
	neral Service Licens			Andrew G	. Gee I			21921 prox	
Sequentially list of any, reading to cause. Enter Unic Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	derlying ar injury	с.	a consequence of):						
tF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc: 5 □ Other (specify) _				ate of delivery onth Day	Year
Pan II. Other Sign	ificant conditions co	nyributing to death b	ut not resulting in the	e underlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to the cause	of death?
R	mici/	cerchin	owda	acq'das	t	1 □ Y	es 2 XNo	3 Probably	Unknown
- A	aturl	Shalla	t'15			24a. Was a autops perform	sv	Were autopsy finding prior to completion death?	of cause of
25. Was case refe	erred to medical				26. Place of De	ath (Check only or	(70.00	
25. Was case reference examiner?		Hospitat: 1 ☐ Inpatie	ent 2 🗌 ER/Outpa	tient 3 DOA Ott	er: 4 Nursing H	Home 5 🗆 Resid	ence 6 🗆 Ot	her (Specify)	
27. Manner of De 1 Natural 2 Accident	ath 5 Pending investigation	28a. Date of Inju (Month, Da	ry Year) 28b. Time (Year) Intur	y Wo	y at rk? Yes 2 □ No	28d. Describe h	ow intury occu	rred	
27. Manner of De 1 Natural 2 Naccident 3 Nucide 4 Homicide 29a. Certifier (Check only one) 29b. Signature ar	6 ☐ Could not be determined	28e. Płace of Inj building, et	ury - At home, tarm, c. (Specify)	street, factory, office		28f. Location (S City or Town	itreet and Num n, State)	ber or Rural Route	Number,
29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	rsician: To the best iner: On the basis of and manner sta	examination and/o	eath occurred at the ti r investigation, in my	me, date and place opinion, death occi	e, and due to the curred at the time, d	ause(s) and mate and place	nanner as stated. , and due to the cau	ise(s)
29b. Signature ar	nd title of certifier	Mu	us	29c. Licens	2 79 75 A	2	29d. Date sign	ed (Month, Day, Ye F/U6	ar)
0.1	dress of person who c	ompleted cause of d	leath (Item 23a) (Type A	pe, Print) May Ma	in nd	Rel	Au.	Mn 2	1014
31. Date fited (Mi	MAY 2 2 2	006 32. egistr	ar's Signatur	Joseph					/

State Registrar

			1 - For State Registrar 1. Decedent's Name (First, Midd		e of Maryla		artmer	nt of H		and N	1ental Hy	giene Reg. No.	200	6	1746
, , , , , , , , , , , , , , , , , , ,	Physici /Medio Examir	cal	Luetta Blanc 4a. Facility Name (If not institution	he Emma		r	4b. City	Town, or	Location of	of Death	Month O5	Day Q3		ear 6 Death	3. Time of Death
	uneral irector		Sacred Hear 5. Social Security Number 234-42-9698	6. Sex 1 M 2		s. last birthday, Yrs.	C	Umb	serlo	bar	8. Date of Bir (Month, Da March	th	Alleg	Birtho	lace (State or Foreign try)
Maryland	a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County WV Mix	neral	10c. C	City, Town or L	ocation								0d. Inside City Limits
ath with the	23a or 28i ust be not	Funeral Director	10e. Street and Number 164 Parkvie	w Drive		<u> </u>		Code 26	726			10g. Citiz	zen of Wha		try?
d 21215-0036 filed within 72 hours after death with the Maryland Hyniane	ral', or itema Examinar m	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🗶 Widowed 4 ☐ Divorced	ried 1 TY	Decedent Ever in d Forces? 'es 2 No , Give or Dates:	U.S. 13.	Was Dece If Yes, spe 1 Yes		ispanic Ori in, Mexican Specity:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Black, Specify:	White, e	
27275- d within 72 h	rthan "natu the Madical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	T	<i>ted)</i> ge (1-4or 5+)	(Give	DO NOT u	se retired	durina mosi		ing		nd of Busin		oply Co.
Maryland 21215-0036 nd 2 should be filed within 72 hours at	Important: If Rem 27 is marked other than "natural", or Rema 23a or 28a-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.	To Be C	17. Father's Name (First, Middle, Milford Cline 19a. Informant's Name/Relations	Rotruc					18. Mothe	ors Name	Blanch	Maiden . e Har	Sumame) riso 1	n	
stand2s	Item 27 is other treur		David S. Dantz 20a. Method of Disposition	ic/ Son	20b.	1	Brae	burn	Driv	re .	al Route Numb Walker: Date	svill)	21793
Baltimore, December: Pages 1 at December: Office	Important: If any injury or once.		t	(pecify)	Pot	tomac M	emori	al G	· 1		y 26 106 Smith Fi		ser,		
/M Exa	edical aminer transit the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	o to (or as a conse	equence of):	taro	tion	7 ac	ute.				2	Interval Between Onset and Death
the death certification	or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	1 ☐ Li 4 ☐ Pi	, outcome of pregr ve birth 2 ☐ Fet regnant at time of nknown	tal death 3	Ectopic pa					2:	3d. Date of Month		y Day Year
Hecords, P.	been signed by the a should be detached f	þ	Part II. Other significant condition		to death but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to				e cause of death?
al necc	this certificate has be al director, page 2 sh	Completed	chronic	y topenia	inaffici	iensy					1 □ Yes	med? 2 No	prior	to com	sy findings available ipletion of cause of
DIVISION OF VITAL RECORDS, P.O. BOX 68/6U, IN ONTRY OF Attending Physicien: The law requires that the death certificate be executed after death.	Olrector: After in by the funer	Certification: To Be	25. Was case referred to medica examiner 1	Hospital: 1 28a. D (A) gation not be	Anpatient 2 Cate of Injury Month, Day Year) lace of Injury - At I uilding, etc. (Spec	28b. Time o Injury	M 2	8c. Injury Work 1 🗆 Y	r: 4 □ Nur	rsing Hon	ne 5 Resid	dence 6 now injury	occurred		Route Number,
To the Hospital	To the Funeral Completely filled	Medical Ce	29a. Certifier (Check only one) 29b. Signature and yttle of certifie	and n	o the best of my kn ne basis of examin nanner stated.	ation and/or in	vestigation,	in my op	number	h occurre	ed at the time,	date and p 29d. Date	signed (M	due to t	ay, Year)
	Sta Registr		30. ame a d address of person Steven R 31. Date filed (Month, Day, Year)	Smith	ause of death (Ite	om 23a) (Type, 90 nature	Print)	ton	٥٢	Cov	nberla	nd .	MD	211	702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ANTOINETTE MENDLER 1405 DOROTHY 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6/13/... 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Hours 077-18-3189 86 Director New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits would item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Suffolk Director Huntington Station N.Y. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11746 85 Olive Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ▼No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 Salesperson Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stubbolo Louis Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Sharon A. Trowbridge/Dau. 1606 Steeplechase Drive Jarrettsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Depertment of Findortant: If its any injury or ot once. 1 A Burial 2 Cremation 3 Removal from State Patrick Cem. 6/5/2006 Huntin ton, N.Y. 4 ☐ Donation 5 ☐ Other (Specify) St. 21. Signature of 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwo Onset and De Immediate Cause (Final Theumonia **Physician** WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner dany landing to immedicause. Enter Underlying Cause (Disease or injury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 HUnknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2□ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

LYNUH

mi.D.

32. Registrar's Signature

Speck

· /Cevin

31. Date filed (Month, Day, Year)

P35012

May

2 North Ave. BelAir, Md. 21014

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DHMH 17 Rev 1/2001

State Registrar

nerdler Arrette

		•	For State Registrar	State of	f Marylan		artment <i>rtificate</i>				lental H	lygiei Reg.	60	06	17467		
	A 2. 8	4	1. Decedent's Name (First, Middle,	Last)							2. Date of Month		Day	Year	3. Time of Death		
	Physicia /Medic	- 5	Thomas	н.	McMa	anus					May	25,	2006		12:22P M		
91	Examin	er	4a. Facility Name (If not institution, g		nber)		4b. City, To			of Death			4c. County				
			Civista Medical 5. Social Security Number 6		7. Age (In yrs.	last hirthday			Lata If Under	24 Hrs.	8. Date of	Righ	Cha	rles	place (State or Foreign		
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200	Hygie Hygie Ather I	ပိ	17. Father's Name (First, Middle, La				-		18. Mothe	er's Name	(First, Mid	dle, Maio	len Suman	ne)			
an	id be ental ked c	To Be	Howard T	. McN	Manus				Leon	ıa		Deg	egenhardt				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Iteme 23a or 28a-1 ehov eny Injury or other traumatic event, Ira Medical Exarch efficiel in the hottlind at once.		19a. Informant's Name/Relationship Diane Mange1/Da				ing Address (D 20659		
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			30. Name and address of person w	ho completed caus	se of death (Iten	n 23a) (Type		, 00	J199								
			Manisha J. Jar	iwala, M	D 11637	Terra	ice Dri	ve	Ste.	103	Waldo	rf.M	arvla	nd 2	0602		
	Sta	te	31. Date filed (Month, Day, Year)	A. A.	legistrar's Signa	ature	all a					,	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#2 per Phy. 1 - State Registrar 5/22/06 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) May 14,20063. Time of Death 2. Date of Death Month Physician Irene J. Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hospital EASTON DI Memorial If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 M 2 KF Yrs 79 07/04/1926 Virgínia 228-28-0833 Director Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a. State 10h County 23a or 28a-f show rthen "natural", or Itame 23s or 28s-f shov the Medical Examiner most by notified at 1X Yes 2 □ No Director Maryland Talbot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21601 29292 Corbin Parkway Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Shoe Industry 12 Manager other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental P Pages 1 and 2 should be ment of Health and Menta tent: If item 27 is marked jury or other treumatic ex Susan Hatcher ပ Henry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Billman/ Daughter 29292 Corbin Parkway Easton, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Roselawn Burial Park 05/17/2006 Martinville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cerebro vasu q /Medical Due to (or as a consequence of) Examiner Eiballation INI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit The law requires that the death certificate be executed protes resulting in death) Last Box 68760 Completed by Physician/Medical use as attending I for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabeters 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 X No 1 Anpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident within 24 hours after deeth To the Funerel Director: completely filled in by the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MX Horid

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Registrar

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s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		10a. State 10b. County MD Prince (Georges	10c. Ci	ity. Town or Lo Temp1	e Hi							0d. Inside City Limits 1 ☐ Yes 2 🏋 No
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification. To Be Completed by Division and the purishment of the purishme	ysicializmed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of the first outcome of the first outcome of the first outcome of the first outcome outcom	2 Feta	al death 3	Ectopic pre					230	I. Date of deliver	ry Day Year
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with To Com	2	29b. Signature and title of certifier	M				License	number	2_		29d. Date s	igned (Month, D	Pay, Year)
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Please Type or Print in Black Indelible Ink. Ensure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Year 2006 5:00 P M Nicholson May 17, Betty Jane /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Edgewater
If Under 1 Year | If Under 24 Hrs. 307 Linden Avenue Anne Arundel 8. Date of Birth (Month, Day, Ye July 21, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1929 Days 1□M 2□F Months Hours Maryland Director 212-66-9102 76 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or itama 23a or 28a-f ahow incermust be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Edgewater Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Linden Avenue 21037 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed f Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic avant, the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Claude King Oda Cline ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert E. Nicholson - Husband 301 Linden Avenue, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or or once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Damascus Methodist Cemetery 5/21/06 Damascus, Maryland 21. Signature of Puneral Service Licen 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Levert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mood of dyes, such as cardiac parasicity arest, Maryland shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) avian Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 25 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death Diractor: / 6 ☐ Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier 1 S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestyate Rd. Annapolis, Md. 00 Selouicu, no Stuaut egistrar's Signature 31. Date filed (Month, State 2006 Registrar

Division of Vital Records.

Maryland 21215-0036

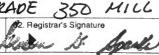
3altimore.

P.O. Box 68760.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and little of certifier



who completed cause of death (Item 23a) (Type, Print)

29c. License number

ST

ORIGINAL

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day RUTH KOONS PLUME Month May 28 2006 11:35 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll County Mount Airy Lorien Mount Airy 8. Date of Birth (Month, Day, Yeer)

Dec. 27, 1915

Pennsylvania If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Min 1 □ M 2 💆 F 90 Months Days Hours 233-34-3405 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Carroll County Westminster Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 United States 1393 Alison Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Jacob Koons Elva Edith Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth P. Fuss / daughter 1393 Alison Court Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State June 2 1 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery Hagerstown, Maryland . `4 □Donation 5 □Other (Specify) 2006 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service License 136 East Baltimore Street Taneytown, Md. 21787 un urur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 200/5 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Experimer must be notified at

Completed by Funeral Director

Be

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with the Maryland

filed within 72 hours aftar death

al Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 Is marked otf

permit. Pages 1 and Department of Health Important: If item 27 any iojury or other tr 000ce.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital or Attanding Physician:

To the Hospital

physician and s the burial-transit the as attending p datachad by the signad t peeu has certificate this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Examine Physician/Medical þ Completed Be 2 Certification:

Medical

3 Suicide 4 Homicide 29a. Certifier

2 Accident

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death accurred at the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work? 1 🗀 Yes

2 🗌 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10005994

29d. Date signed (Month, Day, Year)

om C. Anel Mo 31. Date filed (Month, Day, Year)

295 Stener AV 32. Registrar's Signature

Registrar

State

JUN 0 2 2006



DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For Stete Registrar	State of Ma	aryıan	-		nt of Hea te of De		vientai	Hygie Reg.	- 211	06	174	73
	Physici	20	1. Decedent's Name (First, Middle, Las	t)						2. Date of		Day	Year	3. Time of Dea	
	Physici /Medic		Kathleen Rogers Pe							May 2		2006		4:30	P^{M}
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. Cit	y, Town, or Lo	cation of Death	1		4c. County	of Death		
			Kline Hospice Hous					Airy				reder			
	Funeral		5. Social Security Number 6. Se	ex 7.Age □M 2ŽŠF	e (In yrs. i 55	last birthday) Yrs.	Month		Under 24 Hrs. lours Min.		, Day, Ye			lace (State or Fo	
L	Director		220-56-5783 Usual Residence of Decedent		25	115.				Marc.	h 12	, 195	1 Ca	lifornia	1
	and w		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Li	mits
	f eh	힏	Maryland Frederic	ck		М	t. A	iru						1 ☐ Yes 2 💆	No
	the 28e	Directo	10e. Street and Number			2.2		ip Code			10g.	Citizen of	What Coun	try?	
	deeth with the Maryland ms 23s or 28e-f ehow crimat be notified at		12402 Catoctin V	iew Drive				2177	1			7.7	C 7		
	The 2	Funerai	11. Marital Status	12. Was Decedent I	Ever in U.	S. 13.	Was Dec		nic Origin? (S Mexican, Puert	pecify Yes o	r No-	14. Rac	S.A.		
12-0030	be filed within 72 hours after deeth with the Marylan Ital Hyglene. Id other than "natural", or litems 23s or 28e-f ehow event, Ita Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:	10				lexican, Puert <i>pecify:</i>	o Hican, etc.	.)		ck, White, y: Whi:		
รุ	2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Us	ual Occupation	n		16b	. Kind of B	usiness/Ind	dustry	
2	within 72 ene. then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	(4)	(Give life.	kind of v DO NOT	vork done durir use retired)	n ng most of wor	king					
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land	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)					18	. Mother's Nan	ne (First, Mi	ddle, Maid	den Suman	ne)		
<u>a</u>		2	Walter Grant Roge	ers					Marjor	ie Ida	a <i>Ell</i>	en La	aundy		
Mar	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (7	Type, Print)		19b. Maili	ng Addre	ss (Street and	Number or Ru	ral Route N	umber, Ci	ty or Town,	State, Zip	Code)	
	s 1 end 2 should f Health and Mer item 27 is marke other treumatic		Bruce E. Pennewill	l (Husban		12402	Cat	octin D	liew Dr			ry, A	lary1	nd 2177	1
9	of Her		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. P	lace of Dispo emetery, crea	sition (N	ame of other place)		Date	20c	. Location	- City or To	wn, State	
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Baitimore,	permit. Pages Depertment of Important: if it eny injury or o		21. Signature of Funeral Service Licen	see		22	2. Name	and Address o	f Facility	J.L.	Dav	ris Fu	neral	Home	
n	40 E 9 9		Jehre Lee	Davis	MOI								aryla	and 2178	3
		_	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ofications that caused one cause on each fir	the death	n. Do not ent	er the m	ode of dying, s	uch as cardiac	or respirato	ry arrest,			Approximate Interval Between	
	Physician		tmmediate Cause (Final disease or condition	a Brain Ca	ancei	:								Onset and Deat	n
	/Medical Examiner		resulting in death)	Due to (or as						-					
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V	and -tran	каш	that initiated events resulting in death) Last	c. Due to (or as	2 000000	uance of):							-		
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68/60 ,	physic the	edicai		. d											
	requires that the death certificate be executed been signed by the attending physicien and hould be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome	of pregna	ncv						224 Da	to of delice		
X O D	atten for u	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	death 3	Ectopic Other (pregnancy specify)					te of delive onth	ry Day Year	
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7	thet the detail	F.	Part II. Other significant conditions co	ontributing to death be	ut not resi	ulting in the u	ndertying	cause given ir	Part I.	23e. (Did tobaco	co use cont	ribute to th	e cause of death	?
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Vital H			OF Was some referred to medical								es 2 💢	No	1 🗌 Yes	2□ No	
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0	Phys r this ral di	5.70	27. Manner of Death	28a. Date of fnju (Month, Da)		ER/Outpatier 28b. Time o		28c. Injury at Work?	4 Norsing H	28d. Descr				поѕртс	
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DIVISION	Attendi death. ctor: A	flea	3 Suicide 6 Could not be	28e. Pface of Inju	ury - At ho	ome, farm, str	reet, fact	ory, office					per or Rura	Route Number,	
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	To the Hospitei or Attending within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exem	ysician: To the best niner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurre vestigati	nd at the time, on, in my opinion	date and place on, death occu	, and due to	the cause me, date	e(s) and ma and place,	anner as st and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				2	9c. License nu	ımber		29d.	Date signe	d (Month, I	Day, Year)	
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			30. Name and address of person tho	completed cause of the	eath (Iten	1 23a) (Tvne)O1O/I			иау	29,	2000		
	10		Diane Juliano, MD,					derick.	Marv1	and 2	1703·	-8624			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** D **Phillips** Richard 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner umberland der 1 Year If Under 24 Hrs. AlleGAM Heart HOSPITAL Acrea 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex ^Y 1931 **Funeral** Days Mar 15, Country 1 M 2 □ F Hours 213-24-7047 75 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a State 10b. County Mode ir then "naturel", or Iteme 23a or 28a-f ehov the Medical Examiner must be nutified at MD Rawlings Allegany 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21557 USA 18811 McMullen Hwv. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ent: If Item 27 Is marked other then "naturel", or Ite Iry or other traumatic event, Ita Modical Examina 1 ☐ Never Married 2 Married 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white ģ 1949-52 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) laborer Potomac Edison 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Earsa Hardman Phillips Alba Phillips ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18811 McMullen Hwy. Rawlings MD 21557 19a. Informant's Name/Relationship (Type, Print) Rose Phillips wife 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State r olaca) 1 Burial 2 Termation 3 Removal from State Scarpelli Funeral Home, P.A. 5/30/2006 Cresaptown Department of Important: If any injury or once. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service License. 22. Nam Scarbelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** Colon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, is aumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit Division of Vital Records, P.O. Box 68760 resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s performed certificate 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient P 2 ER/Outpatient 3 DOA this After this funeral of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e filled Certifying Physician: To the best of my knowledge, death consider the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24a Carthet Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 Name and address of person who completed cause of death (Item 23a) (Tile, Print)

State
Registrar

31. Date filed (Month, Day, Year)

JUN 0 2 2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Pinkney 5:00A M Ronald Wayne 25. 2006 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year | II Under 24 Hrs. Holy Cross Hospital Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 CT 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 ☐ F 34^{Yrs} 040-76-5415 9, Director 1972 May Usual Residence of Decedent death with the Maryland 10c. City, Town or Location and Mental Hygiene. is marked other then "natural", or liems 23a or 28a-f ehow aumatic event, the Mudical Examiner mast be multified at 10a. State 10b. County 10d. Inside City Limits 1- Yes 2 □ No Funeral Director Gaithersburg MD. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 76 Timber Rock Road 20878 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ 3 Widowed 4 Divorced B1ack Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked None 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ Ronald Alexander Estonya Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9945 Good Luck Lanham, MD 207 Rondale W. Pinkney Hudson/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 6/1/06 4 □ Donation 5 □ Other (Specify) Landover, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 anice Eduards 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asystole disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed g physician and as the burial-transit Portal Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy lindings available prior to completion of cause ol death? 24a. Was an autopsy performed? After this certificate 1 ☐ Yes 2 🔯 No 1 Yes 2€ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🔀 No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Injun 1 XNatural 5 Pending death. 1 ☐Yes 2 ☐No investigation filled in by the f 2 Accident 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide after To the Hospital o within 24 hours af To the Funerel D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63738 May 25, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anjuman Ara, M.D., 3127 Helsel Dr., Silver Spring, MD. 20906 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

Paul Denver Proc	tor	Ctata			Print in Black In				
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Physician Medical Examin	n/ er	Paul			D	_	Date of De Month	Day Year	3 Time of Death
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3		Lloyd Bowen Road	vo strott and mamber)		St. Leon		or Death	4c County of Dear	tn
Funeral	7	Social Security Number 6. 8	ex 7 Age (In	r vrs. las	birthday) If Under 1		er 24Hrs 8. Date of B		rthalass (Ctata
Director	- 1				Months	Days Hours	Min.	Fore	orthplace (State or ign Wash. DC
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2 hou mat	ě	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of working			16b. Kind of Business	industry
36 hin 7 e than edica	흵	12			Water Open	rator		WSSC	
d wit	Completed	17. Father's Name (First, Middle, Last)		water open		's Name (First, Middle,		
215-0036 be filed within 7 ntal Hygiene 'ked other than ent, the Medica	8	Alfonso	ī	Prod	ctor		zabeth		roctor
4D 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she marter of the Medical Examiner must be notified at once		19a Informant's Name/Relationship (Гуре, Print)	100	19b. Mailing Address (S				
MD d 2 shc lth and n 27 is		Valerie Proct	or / Wife		2085 Natu				
	Ī	20a Method of Disposition			ce of Disposition (Name of		Date	20c. Location - City or	
Baltimore, permit Pages I an Department of He. Important: If ite		1 X Burial 2 Cremation 3	_		matory or other place)		- 04 0-		
it Portan	1	4 Donation 5 Other Specify 21. Signature of Funeral Service Lieu		Kes	urrection		6-01-06	Clinton	MD
Balti permit Departu Importi			Issee	100	22. Name and Addr		20	605 Aquas	co RD
Physician	+	23a. Part I. Enter the disease, or com	plications that caused the	191	Adams Fu	<u>ineral</u>	Home PA	Aquasco	
/Medical		failure. List only one cause on e	ach/line.				ardiac or respiratory an	rest, snock, or neart	Approximate Interval Between Onset and
Çxaminer	- 1	Immediate Cause (Final disease a or condition resulting in death)			l ethanol intoxi	cation			Death
\		h h	Due to (or as a conseque	nce or).					
	<u></u>	if any, leading to immediate	Due to (or as a conseque	nce of).					-
-	틹	Cause. Enter Underlying Gauss (Disease or injury that initiated C.							
pg tist	Examiner	events resulting in death) Last	Due to (or as a conseque	nce of):	-				
and and		d.	i tom#	1 22	1,27,28a-f,perME	1 -057 7	16 loc m		
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	<u></u>		AMENDED ILEIH	1,20	1,27,20a-1,penvir	.,g&)/,//	/6/06 TT		
box 68760). Box 68760 the death certificate by the attending physiched for use as the burner as the	Ž	IF FEMALE: 3b Was decedent pregnant in the	23c. If yes, outcome of	pregnar				23d Date of delivery	
c 68	<u>a</u>	past 12 months?	Pregnant at time	of death	2	3 Ectopic	pregnancy	Month (Day Year
BOy death he att	<u>s</u>	1 Yes 2 No 9 Unknow	9 Unknown		5 Other (Specify)				
that the		Part II. Other significant conditions	contributing to death but	not resu	lting in the underlying caus	se given in Pai	rt I. 23e. Did to	obacco use contribute to	the cause of death?
b, P.O.	6						1 Yes	s 2 No 3 Prob	pably 4 Unknown
ords,	Completed							an 24b Were au	topsy findings available
COF law 1 has b							autop		ompletion of cause of
tal Rection: The certificate ector, page	3						1 🗸 Yes		s 2 No
Division of Vital Records, tall or Attending Physician: The law require and the standard After this certificate has been sitted in by the funeral director, page 2 should be difficultion. To Do Complete	as I	25. Was case referred to medical examiner?	lospital:		26.Pla		Check only one)		
n of Vit	2	1 Yes 2 No	I Inpatient		R/Outpatient 3 DOA	Other ₄		Residence 6 V Other	Scene
J O Ling	<u> </u>	27. Manner of Death 1 Natural 5 Deading	28a. Date of Injury (Month, Day,Year)	28		njury at Work?		how injury occurred	
ivisior Ior Attendath Or Control Director:		2 Accident Pending Investigati	on Fnd 5/24/200		101 7.50 pm	Yes 2X	Dabject 1	ingested drug a	and alcohol
Or A Briter Direction by Timb		3 X Suicide 6 Could not	De		e, farm, street, factory, offic		28f. Location (S	Street and Number or Ru	ral Route Number, City
Division o Hospital or Attending 24 hours after death 25 femeral Director: After tilled in by the function	5 L	4 Homicide determine	(Specify) Fnd:	in fi	eld next to pid	k−up tru	ck St. LEona	ard , MB Bowen	Kd.
e Hos		29a Certifier 1 Certifying Physic	an: To the best of my kno	wledge,	death occurred at the time,	date and place	ce, and due to the caus	e(s) and manner as start	ed
Division of Vital Records, P.O. Box 68760 To the Itospital or Attending Physician: The law requires that the death certificate b within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the building of Completely filled in by the funeral director, page 2 should be detached for use as the building of Completely filled in by the funeral director, page 2 should be detached for use as the building of Completely Filled in by the funeral director, page 2 should be detached for use as the building of Completely Filled in by the funeral director, page 2 should be detached for use as the building of Completely Filled in by the funeral director, page 2 should be detached for use as the building of Completely Filled in the funeral director, page 2 should be detached for use as the building of Completely Filled in the funeral director, page 2 should be detached for use as the building of Completely Filled in the funeral director, page 2 should be detached for use as the building of Completely Filled in the funeral director, page 2 should be detached for use as the building of Completely Filled in the funeral director and the	ed L		On the basis of examinat and manner stated	ion and/	or investigation, in my opini	on, death occ	urred at the time, date	and place, and due to the	e cause(s)
= > = 0 \$	Σ	29b Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mor	nth, Day, Year)
11		Pote Ilian	200	1	0.0	C.M.E.		May 25, 2006	
KB		30. Name and address of person who	completed cause of death	(Item 23	a)			L	
1 obserding	1	Patricia Aronica-Pollak MD). Assistant Medic	cal Exa	aminer 111 Penn	Street, Bal	timore, MD 2120	1	
Stat	е	31. Date filed (Month, Day Year)	200 32. Reservar's Sig	gnature	4 Roads				
Registra	-	0	LOOP JOSEPH	s s					

		1	1- State of Man		rtment of Hea tificate of De	lth and Mental Hy ath	ygiene 2	006	17477
	Physici		1. Decedent's Name (First, Middle, Last) Martha Lee Q	uade		2. Date of D Month May 1	Day	Year 6	3. Time of Death 3: 25 P M
). 	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) St. Mary's Hospital 5. Social Security Number 219-42-2728 6. Sex 1 □ M 2 ☑ F	In yrs. last birthday) 62 Yrs.		ation of Death WIN Judger 24 Hrs. 8 Detect of R	4c. Cou St	unty of Death . Mary!	ace (State or Foreign
	D D	_	Usual Residence of Decedent 10a. State 10b. County 11	Oc. City, Town or Loc			,		d. Inside City Limits
	with the Ma a or 28a-f	Director	Maryland St. Mary's 10e. Street and Number 26938 Laurel Grove Road	Mechan	icsville			of What Count	1 ☐ Yes ZXXNo
980	y within 72 hours after death with the Maryland liene. r than "natural", or Iteme 23a or 28a-f ehow the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Marital	lf.	3737	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	E	A Race - America Black, White, e ecify: White	otc.
Maryland 21215-0036	within 72 ho ene. than "natur in Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)	(Give k	ent's Usual Occupation kind of work done during O NOT use retired) maker	g most of working	16b. Kind o	f Business/Indu	ustry
land 5	id be filed ental Hyg ked othe ic event,	To Be Co	17. Father's Name (First, Middle, Last) Thomas Elmer Quade	none	18.	Mother's Name (First, Middlerry Joseph Burro	e, Maiden Surr		
	s 1 and 2 shoul f Health and Mt Item 27 Is marl other traumati		19a. Informant's Name/Relationship (Type, Print) Thomas Franklin Quade / Brother		Laurel Grove	Number or Rural Route Num Road, Mechanicsv Date	ille, Mar		0659
Baltimore,	Page: nent o ant: If ary or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	St. Joseph's	s Cenetery	May 25, 2006	Morganz	za, Maryl	
Ba	Departi Departi Imports eny Inji		23a. Pant. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on such line.	P	.U. Box 2/U,	Facility diner Funeral Ho Leonardtown, Mar ch as car lac or respiratory	yland 206		Approximate Interval Between
8760,	The law requires that the death certificate be executed XB XX the has been signed by the attending physician and be detached for use as the burial-transit or in the part of t	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)		remanage Held	up De	~		Onset and Date
.O. Box 6	it the death certific by the attending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	∃Fetal death 3⊟8	Ectopic pregnancy Other (specify)			Date of delivery Month C	y Day Year
rds, P	equires that en signed b	by	Part II. Other significant conditions contributing to death but n	not resulting in the unc	derlying cause given in				cause of death?
al Records,		Completed	CORD			24a. Wa aut per 1 🗌 Yes	s an 24 opsy ormed? 2 No	b. Were autops prior to com- death? 1 \(\sum \text{Yes} \) 2	sy findings available pletion of cause of
Division of Vital	ial or Attending Physician: The safter death. I Director: After this certificate od in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	- At home, farm, stre	3 DOA Other: 4 28c. Injury at Work? M 1 Yes	2 No	how injury occ		
B	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of no the basis of example and manner states 29b. Signature and the of certifier 30. Name and address of person who completed cause of deat	ramination and/or inve	estigation, in my opinion 29c. License nun	n, death occurred at the time	, date and plac	manner as staller, and due to the sined (Month, Daniel 23	the cause(s)
	Sta Registi			e Notch Road Signature		Maryland 20636			
DH	MH 17 Rev 1/2	001	your	ORIGIN	VAL				

		For State Ragistrar	State of Mar		artment ertificate			-	giene Rag. No. 🤈 🕦	nc	1 -7]7 (
		Decedent's Name (First, Middle, La	st)					2. Date of De	ath	10	3. Time of Death
Physic /Medi		Donald Glenr	Rodeheaver	•				Month	Day 22	Year	10:40 A.M.
Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. City, 7	Town, or Loc	ation of Death	,	4c. County o	f Death	
		SACred HEAD	2+ HOSPIT	al	CU	mbek	2 lanc		Alle	GAM	
Funeral		5. Social Security Number 6. S	WM 2□E	In yrs. last birthday	Months		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	y, Year)	Country	
Director		215-26-9978 Usual Residence of Decedent		76 Yrs.				March	28,1930	Deer	Park, MD
land ow		10a. State 10b. County	1	0c. City, Town or I	ocation					10d	. Inside City Limits
Many	ţ	WV Minera	1	Bur1	ington						1 ☐ Yes 2 No
death with the Maryland me 23e or 28e-1 ehow mant be notified at	Director	10e. Street and Number		-	10f. Zip				10g. Citizen of WI	hat Country	?
th wit		Rt. 1, Box 101				26710)		U	SA	
<u> </u>	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	Was Decede If Yes, speci 1 Yes 2		nic Origin? (Sp exican, Puerto pecify:	pecify Yes or No Rican, etc.)	- 14. Race Black Specify:	- American , White, etc	
		15. Decedent's E		16a. Dec	edent's Usua	Occupation		,	16b. Kind of Bus		
d Z1Z1S- filed within 72 Hygiene. ther then "nel ent, me Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Giv	e kind of wor DO NOT us	k done during e retired)	g most of work	ring			
	Com	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4	E	nginee	r			Ballist:	ics La	aboratory
	Be (17. Father's Name (First, Middle, Last)			18.	Mother's Nam	e (First, Middle,	Maiden Sumame)	
	ပို	Leslie H. Rode						a Marie			
re, Maryl8 s 1 and 2 should l Health and Mer ltem 27 16 marke other traumatic	5 8	19a. Informant's Name/Relationship (1				al Route Numbe	er, City or Town, S	tate, Zip Co	ode)
C, R 1 and Health Health Health	1 3	Verna H. Rodehea	ver/WIfe	Rt 20b. Place of Disp	. 1, B		Bur1	ington,			Chan
0 90= 5		1 Burial 2 Cremation 3		cemetery, cri	ematory or ot	her place)	May		20c. Location - C		
		4 Donation 5 Other (Special 21. Signature of Funeral Service Lices	4	Deer Par			200		Deer Pai)
Dail permit. Departi Import. any inj	1	21. Signature of Funeral Service Licen	B X 11	The					eral Home		
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Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	ephalo	pat	hy					terval Between nset and Death
death certificate be executed to attending physicien and tor use as the burial-transit to	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c		<u> </u>	ANCE	2 (4	weeks
TO BOX 61 If the death certific by the attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pre				23d. Date Mont	,	ly Year
COTGS, P wrequires that been signed b should be deta	<u>م</u>	Part II. Other significant conditions of	contributing to death but r	not resulting in the	underlying ca	iuse given in	Part I.	23e. Did to	obacco use contrib res (No 3	oute to the d	
has has	Completed							24a. Was autor perfo	osy pri rmed? de	ath?	r findings available letion of cause of
	0	25. Was case referred to medical			-	26.	Place of Deat	1 ☐ Yes		Yes 20	7/10
T V ysici ysici is ce direc	ToB	examiner? 1 ☐ Yes 2⊠No	Hospital: 1 (npatient	2 ER/Outpatie	ent 3 🗆 D0/	Other: 4	☐ Nursing Ho	ome 5 Resid	dence 6 □Other	(Specify)	
n OT ng Phy ter this neral d		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time Injury	of 28	c. Injury at Work?		28d. Describe h	now injury occurred	1	
ISIOI ktendir death. ctor: Af	atle	2 Accident investigatio	n		М	1 🗆 Yes	2 No				
UNISION OF VITA To the Hoepital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)				City or Tov			
the Hoep in 24 hou the Fune pletely fil	Medical	29a. Certifier (Check only one) 2 Medical Example (Check only one)	nysician: To the best of r niner: On the basis of ex and manner state	camination and/or i	th occurred a nvestigation,	it the time, da in my opinior	ate and place, n, death occur	and due to the red at the time,	cause(s) and manr date and place, an	ner as state id due to the	ed. e cause(s)
To To E	2	29b. Signature and title of certifier		/	29c.	License nun	nber	\$	29d. Date signed (-	
Λ.		0	wi' m		1	30054)	479		5/22/2	2006	>
* Y		30. Name and address of person who	1MD 925	5 Kisho	Print)	340	ad.	Cum Co	rland,	ND	2(502
St Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registrar's	Signature	de		(- (

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>006</u> **Physician** 27. Martha Mav 2:20am Agnes Renner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Citizens Nursing & Rehab Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1□M 2\ F Yrs. 197-10-1115 99 Philadelphia,PA Director Usuat Residence of Decedent 10c. City, Town or Location 10d. toside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, it a Madical Examinar must be notified at once. Maryland Frederick Frederick 1 X Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gleckler John В. Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marie Hoppe, Niece 601 Wilson Place, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Greenmount Cemetery Jun 2,2006 Philadelphia, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Life se 22 Keenev & Bastord P.A. Funeral Home ₩00706 106 East Church St, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Dementia 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuguence of) Examiner the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Anemia autopsy 2 XXIXIO 1 Yes of Vital 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2KXVo To the Hospital or Attending Phys within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral directions. this 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 5 Pending investigation 1 X X atural 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier May 30, 2006 D30496 20 ny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis E. Becker, M.D., 300 West Ninth Street, Frederick, Maryland 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 2 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

	•	1	For State Registrar		State o	f Maryla		oartmer e <i>rtifica</i> i		ealth and N Death		iene	06		81
	Physicia		1. Decedent's Name (First, Midd				Calaeffa				2. Date of Dea Month	Day	Year	3. Time of D	Death M
	/Medic	al	Evelyn 4a. Facility Name (If not institution	A.	reet and nu		Schaffe		. Town, or	Location of Death	MAY 28,		y of Death	0336	
	Examin	er	Memorial Hosp		7001 2270 110	,,,,,,			MBERL				GANY		
	uneral irector		5. Social Security Number 216-22-5355	6. Sex 1 □	M 2 □ X =	7. Age (<i>l</i> n y	rs. last birthda Yrs.	y) If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Jan 5,	Ť 9 24	9. Birth Cou	place (State or	Foreign
faryland	ed at		Usual Residence of Decedent 10a. State 10b. Count MD Alle	gany	<i>y</i>	10c.	City, Town or Cur	Location nberla	nd		-			10d. Inside City	
with the N	a or 28a-	Direct	10e. Street and Number 830 Williams S	Street	<u> </u>			10f. Zi	p Code	21502	1	0g. Citizen of	What Cou	intry?	
-UU36 hours after deeth with the Maryland	ritien "naturel", or Items 23a or 28a-1 ehow The Modical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1	2. Was Dec Armed F	2 XNo	n U.S. 13	3. Was Dece If Yes, spe 1 \(\subseteq Yes	Y	spanic Origin? (Sr n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	ВІ	ace - Amer ack, White ify: wh		
d within 72 hours af	Madical I	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Educ est grade	completed) (1-4or 5+)	(Gi	. DO NOT	<i>ork d</i> on <i>e d</i>	during most of wor	king	16b. Kind of		ng Hom	e
	d othe	Be	17. Father's Name (First, Middle John Sivic	, Last)			Italo			18. Mother's Nam France	ne (First, Middle, S (Thom	Maiden Suma	me)		
Maryland id 2 should be file	in and menta 27 is marked treumatic ev	၉	19a, Informant's Name/Relation Karyl Kuykend	all Typ	ов, Print)	laughte	er 83		s (Street a	Street	ral Route Numbe Cumi	oerland	n, State Z	D 2150	2
ore, es 1 an	Department of neatin and wer Important: if item 27 is marks eny injury or other treumatic obce.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (amoval fron	State S	b. Place of Dis cemetery c St. Mary's	position (Na rematory or Cemet	ame of other place CFY	e)	Date 6/5/2006	20c. Location	-		ID
Balti permit.	Important: Important: eny injury o		21. Signature of Funeral Service	Dy	1	aix	lle	10	08 Virg	ii Fūneral H ginia Avenu	e: Cumber		2150		
//	ysician Medical aminer		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complidest only on	b cause on	each line.				g, such as cardiac				Approximate Interval Betw Onset and D	veen leath
760, Ite be executed	ysicien and e burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	Due to		isequanca of):								
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ds, P.	5 8	5	Part II. Other significant condi	tions con	tributing to	death but no	t resulting in the	e underlying	cause giv	en in Part I.		obacco use co ′es 2□No		the cause of de	
Records, P.O The law requires that the	nis certificate has been si I director, page 2 should	Completed									24a. Was autop perfo 1 🗆 Yes	rmed?	prior to death?	topsy findings a completion of ca	
of Vital Physician: T	ector,	Be	25. Was case referred to medi- examiner?		ospital:				Oth	or	ath (Check only o				
o §	After tl unera	tion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Peninger		1 1	Inpatient e of Injury onth, Day Yea	2 ☐ ER/Outpa 28b. Tim ar) Injud	e of	28c. Injur Wor	4 Linuising i	dome 5 Resident Resid			cify)	
Division	fter deal	Certification:	3 ☐ Suicide 6 ☐ Cou	-	28e. Pla bui	ce of Injury - ding, etc. (S	At home, farm, pecify)	, street, facto	ory, office		28f. Location (S City or Tov		mber or Ru	ural Route Numi	ber,
Letiqsotte	within 24 hours after deat To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certification (Check only one)	ying Phys al Examir	ner: On the	best of my basis of exa unner stated.	y knowledge, d mination and/o	eath occurre r investigation	ed at the tir on, in my o	me, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
Toth	withiu To th	Me	29b. Signature and title of cent	lier	/-	2			9c. Licens	se number		29d. Date sig		h, Day, Year)	
	10		30. Name and address of person						Ma	ruland 01	1502				
		ate	Vik Poonai MD 31. Date filed (Month, Day, Ye	ar)	22	Registrar's	Signature		, rid	ryland 21					
394.	Regist	trar	JUN 0 2 2	006	Marie	20	App	No.							

		•	1 - For State Registrar	State o	f Marylar		artment rtificate			ind M		giene Reg. No.	0 0 E	174	82
	Physici	an	Decedent's Name (First, Middle, Evelyn	Laverne		Sheetz					2. Date of Dea	7, 2006	Year	3. Time of Dea 2:18 am	
	/Medic Examin		4a. Facility Name (If not institution, 12603 Irons Mt.	give street and nui		nociz		Town, or nber	Location o land	f Death	may 2	4c. Cour	nty of Deat		
	Funeral Director		218-24-7817	.Sex 1 □ M 2 □ X F	7. Age (In yrs. 78	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt Month, Da Aug 9	1927	9. Birt Co	thplace (State or Fo	oreign
	Maryland a-f ehow	ctor	10a. State MD Alleg	any	10c. Ci	ty, Town or Lo	berlar	nd						10d. Inside City L	
	h with the 23a or 28 at the con	al Director	10e. Street and Number 12603 Irons Mt.	Road SE			10f. Zip		21502	2		10g. Citizen d	of What Co	ountry?	
9036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or items 23s or 28s-f ehow aumatic event, the Medical Exameter must be excitled at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 □ x No ⁄e		Was Deced If Yes, spec	Y	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		ace - Ame lack, Whit		
Maryland 21215-0036	od within 72 ha giene. or then "natu , the Medical	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		I-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	uring most			16b. Kind of	Bure	,	
land	uld be file fental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, La John M. Irons	est)							(First. Middle. osella V			S	
Mary	ind 2 shorestith and No. 27 is ma		19a. Informant's Name/Relationshi Clarence Sheet	(Type, Print) h	usband	19b Maiii	03 Iro	(Street a	it. Ro	r or Rura ad S	E Cum	oerland	n. State	70°21502	
Baltimore,	permit. Pages 1 and 2 should be Department of Heelith and Menta Important: If Item 27 is marked any Injury or other traumatic et angoge.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State Da	Place of Dispo cemetery, cre IVIS MEM	sition (Nam matory or of Orial C	ne of ther place emete	jry ¦		ate 5/31/2006	20c. Locatio Cumi)
Bail	Departi Departi Import any in		21. Signature of Funeran Service Li	4.00	upal		10	8 Virg	jinia Av	venue	ome, PA :: Cumbe		D 215	02	
	The law requires that the death certificate be executed X X All has been signed by the attending physicien and age 2 should be detached for use as the burial transit The law requires that the law requirements the law requirements that the law requirements that the law requirements that the law requirements that the law requirements that the law requirements that the law requirements that the law requirements the law requirements the law requirements the law requirements that the law requirements	dical Examiner	23a. Part1. Enter the disease of coshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	cor as a consection as a conse	quence of):	AR C	i ~le:	M A	¢ ←	PAN	CRANS		Approximate Interval Betwee Onset and Deat	th
P.O. Box 6	that the death certifica led by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live t	tcome of pregnioith 2 Teta nant at time of cown	aldeath 3[Ectopic pro						Date of del	livery Day Year	r
Division of Vital Records, P.	w requires that been signed by should be deta	b	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	es 2 Xio	3 □ Pr	the cause of death	nown
al Rec	: The lav cete has page 2	Completed									autor		prior to death?	completion of cause	e of
Z.	Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medicat examiner? 1 Yes 2 40	Hospital:	Inpatient 2	ER/Outpatier	nt 3 00	Othe	26. Place or: 4 ☐ Nu		ne 5 Resid	ne) dence 6 □0	ther (Sne	cufv)	
ion of	Attending Phy ir death. ector: After this by the funeral c		27. Manner of Death 1 Autural 5 Pending 2 Accident investiga	28a. Date (Mon		28b. Time o Injury		8c. Injury Work		2	28d. Describe f			City)	
Divis	al or Attendes after death	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 280. Place	of Injury - At h ing, etc. (Speci	ome, farm, st	reet, factory	r, office		2	28f. Location (5 City or Tox		mber or Ru	ural Route Number.	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical C		Physician: To the band man											
\	To the To the comp	M	29b. Signature and title of certifier	11	1		290	. License	number			29d. Date sig	ned (Mont	h, Day, Year)	
,			20 Name and a size	mal	and death /	m 23a) /Tuna	Print)	D42	054			May 3	0, 20	006	
	7		30. Name and address of person w Gregg C. Donald					; Cui	mber1	and,	MD 21	502			
	Sta Regist		31. Date filed (Month, Day, Year)	32. F	Registrar's Sign	ature									

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 0119 Donald Wayne Sweeney 30 MAY 7000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hage Is Low I.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 1948)

Months | Days | Hours | Min. | October 21, Washington County Hospital Washington 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1MM 2□ F Yrs. 57 Director 216-48-6581 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at , 12 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 13 West Baltimore Street U.S.A.12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: <u>۾</u> 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ie marked other then College (1-4or 5+) Elementary/Secondary (0-12) Labor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be d 2 should be f h and Mental h Peggy L. Miller Joseph Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. 5769 Sunset View Lane Frederick, Maryland 21703 (Sister in Law) Anna Crummitt Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State June 2, 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2006 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home אוסח 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the ettending physician and the detached for use as the burial-transit be executed enemones Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown should should annon Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy ence 1 ☐ Yes 2 2 No of Vital within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2. No 1 Inpatient 2 ER/Outpatient Certification: To 1 ☐ Yes 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year 1 Natural 5 Pending 1 | Yes 2 | No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 5 To the Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Kal 25 ra 31. Date filed (Month, Day, Year)
JUN 0 2 2006 32. Registrar's Signature State Registrar

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		-	For State Registrar			d / Depa	artment of H	ealth a		ental Hygie	ene 1. No. 2 (006	17484
	Physicia		1. Decedent's Name (First, Middle, La		n Ferne Se	elby			1	2. Date of Death Month	Day	Year O6	3. Time of Death Q1;30 M
	/Medic Examin	er	4a. Facility Name (If not institution, gires SACRED HEAR)	re street and num	ber) エTAL		4b. City, Town, or	BERL	SUY.	•	4c. County	of Death LEGA	Yui
	Funeral Director			Sex 1□M 2 X F	7. Age (In yrs. 1	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,) September	(ear) 17, 1919	9. Birthpi Coun	ace (State or Foreign try) Maryland
	Maryland I-f ehow	tor	10a. State 10b. County	llegany	10c. City	y, Town or Lo	cation	Cumbe	rland			10	od. Inside City Limits 1 XYes 2 □ No
	with the	I Direc	10e. Street and Number 505 1	/2 Beall Stre	eet		10f. Zip Code	2150)2	10	g. Citizen of V	What Coun US	
36	d within 72 hours after death with the Maryland liene. Than naturell, or Items 23s or 28s-f ehow the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	2 X No		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Orig in, Mexican Specify:	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		e - Americ ck, White, e	
Maryland 21215-0036	within than than	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	ducation rade completed) College (1	4or 5+)	16a. Dece (Give life.	dent's Usual Occupi kind of work done o DO NOT use retired	ation during most () Secretar		g 10	6b. Kind of Bu	usiness/Ind	
land 2	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Las	ranklin Lov	vdermilk			18. Mothe	r's Name	(First, Middle, Mi	aiden Suman hel Griffi		
Mary	d 2 sho th and 7 ts m traum		19a. Informant's Name/Refationship Allen E			19b. Mailii	ng Address (Street a			Route Number, , Cumberla			
Baltimore,	Pages 1 and nent of Heelt int: If Item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		1 0	emetery, crei	osition (Name of matory or other place dison Cemete		Da	May 22, 2006	oc. Location - Addi		wn, State nnsylvania
Balti	permit. Pages Depertment of Important: If it eny Injury or o		21. Signature of Funeral Service Lice	MA	ak A		2. Name and Addres EICHNO		Lona	aconing Mo	1. 21539	8 East	Main St.,
760,	Physician // Medical Examiner pulsicieu au physicieu au p	Ilcal Examiner	23a. Part1. Enter the disease, or conshock, or heart faifure. List only immediate Cause (Finaf disease or condition resulting in death) Sequentially list conditions, if any, leading to unimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Bic. Due to (c.		uence of):	A IND MYS					7	Onset and Death Wis DAY
.O. Box 68	ne death certif the ettending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		rth 2∐Feta antattime ofd	death 3	Ectopic pregnancy Other (specify)	/				ite of delive	Day Year
Δ.	w requires thet the consideration of the considerat		Part II. Other significant conditions			-	inderlying cause giv	en in Part I.					ne cause of death? ably 4 []Unknown
Il Records,	: The law recete hes been pege 2 sho	Completed by								24a. Was an autopsy perform	ed?	Were auto prior to cor death? 1 Yes	psy findings available inpletion of cause of
of Vital	ysicien: Th is certificete director, peg	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA Oth			<i>(Check only one</i> ne 5 ☐ Resider		ner (Specify	1)
Division o	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	on be 28e. Place	h, Day Year)		Wor	yat k? Yes 2⊡i	No	8d. Describe how 8f. Location (Stri City or Town,	et and Numb		il Route Number,
_	Hospita 24 hours Funerel letely fillec	Medical C	29a. Certifier 1 Certifying (Check only one)	aminer: On the ba	best of my kno asis of examina ner stated.	owledge, dear ation and/or in	th occurred at the tire	ne, date an opinion, dea	d place, a	nd due to the car d at the time, da	use(s) and mate and place,	anner as st and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of centifier	live-	-us		29c. Licens		(MAN	29 (CM)	d. Date signe		
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	St Regist	ate rar	31. Date filed (Month, Day, Year)		egistrar's Sign		Acesto						

State of Maryland / Department of Health and Mental Hygiene UUD

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 April 20, **Physician** 2:15 P Rosa Stogner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf Waldorf Healthcare Center If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 ☐ M 2 🖸 F 92 Director 579-12-2988 <u>March 31, 1914 North Carolina</u> Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 le marked other then "natural", or Items 23s or 28e-1 show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4140 Old Washington Road 20602 U.S.A. by Funera permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If I tem 27 ie marked other then "natural", or the any injury or other treumatic even. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susan Aida Draughn John Rousen Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13201 Martin Road, Brandywine, Maryland Joan King / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2006 Davidsonville, MD Lakemont Memorial 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMORSTIVE **Physician** disease or condition resulting in death) month ? /Medical Due to (or as a consequence of) Examiner CODINOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes 1 🗌 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after of To the Funerel Direct completely filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature, and title 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Sate 100 017 626 Contas 32. Registrar's Signature 31. Date filed State Registrar

			1- For State of Maryland / Dep	partment of Health and N e <i>rtificate of Death</i>		ene	17486
	Physici	3.0	Decedent's Name (First, Middle, Last) Ellen Jean Saling		2. Date of Death Month May	23 ^y , ž ů 6	3. Time of Death 6 2:03 P M
1	/Medic Examin	P.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	LAGIIIII	٠,	St. Mary's Hospital	Leonardtown		St. Mar	y's
	Funeral Director		5. Social Security Number 6. Sex $1 \square$ M $2 \times 1 \longrightarrow 1$ 7. Age (In yrs. last birthda $1 \square$ M $2 \times 1 \longrightarrow 1 \longrightarrow 1$ 7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) August 4,	9. Bir 1924 I11	thplace (State or Foreign ountry) inois
	P .		Usual Residence of Decedent				Last to the object to
	anylar ehow	7	10a. State 10b. County 10c. City, Town or Maryland St. Mary's Leonard				10d. Inside City Limits 1 XYes 2 No
	the M	ecto	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	
	with 8e or	10	22680 Cedar Lane Court, Apt. 1214	20650		USA	odiniy.
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
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lar	s 1 and 2 should I Health and Men Item 27 Is marke other treumatic		1 1 1 1	iling Address (Street and Number or Rui		-	Zip Code)
	Pages 1 and 2 ment of Health 3 ent: If item 27 li ury or other tre			Box 110 Valley L			Town Chata
ore	W		1 Burial 2 □ Cremation 3 □ Removal from State Cemetery, contains Telephone Telephon	rematory or other place)	-	Oc. Location - City or	
altimore,	400		4 Bonandi 6 Bona (openy)	Memorial Gardens May 2			iics, IIIIiiois
Ba	Depar Impor any ir		Muchael & Hardiner	22 Name and Address of Facility Fun Mattingley-Gardiner Fun P.O. Box 270, Leonardto	wn, MD 2065	50	
т			23a. Part 1/ Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				2542
	Examiner		Due to (or as a consequence of):	Imonung Hy	Cer ten	ging	>5 m
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Umonury Hy N A. fib			25.42
68760,	ficate be executed physician and s the burial-transit	ai Exa	resulting in death) Last Due to (or as a consequence of):	,			
687	ficate physics the	edicai	d				110
Вох	death certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	NIG	+	23d. Date of de	livery N16+
.O. B	the than	Physician/M	in the past 12 months?	B⊟Ectopic pregnancy □ Other (specify)	,	Month	Day Year
Q	es that thighed by		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quires in sign	ed by	. 4/0 Brist cancer		1 ☐ Yes	2 No 3 P	robably 4 Munknown
Records,	aw requir s been si 2 should	Completed	Dusphasia, Hylonifiamia	Hypothynory	24a. Was an	24b. Were a	utopsy findings available
R	The lav	mo			autopsy performs	death?	completion of cause of
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Deal	th (Check only one)		1.0
of V	Physicien: r this certifica ral director, I	To	1 ☐ Yes 2 No Hospital: 1 npatient 2 ☐ ER/Outpat		ome 5 Resident	ce 6 □Other (Spe	cify)
ion o	nding Physicien: The ath. T: After this certificate ha funeral director, page	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		28d. Describe how	rinjury occurred	
Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	omple	Mec	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	h, Day, Year)
	F > F 0		· War	D0062213	3	5 23 0	6
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		\/	12 D
-	- 6		Syresh H. Partel, MD, 22650	LEDAR Lune ct	Leon	nard tou	, 2.650
	Sta Registi		31. Date filed (Month, DMAN) 2 4 2006°2. Recetrar's Signature	Suck !			

			For State Registrar	State	of Marylan	-	artment of H		Mental Hyg	iene 0 0 6 og. No.	5 17487
	Physicis		1. Decedent's Name (First, Middle, I						2. Date of Deat Month	n Day Yea	
Q.	Physicia /Medic		Dora	н.	Stiles		T		May 16,		1:15 P M
	Examin	er	4a. Fecility Name (If not institution, g	ive street and n	umber)		4b. City, Town, or		ith	4c. County of De	
			10 Grays Road 5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday)		Nood If Under 24 Hr	s. 8. Date of Birth	9.5	Arundel
В	Funeral Director		151-01-6680	1□M 2∰F	90	Yrs.	Months Days	Hours Mir		Year)	Country) ew Jersey
	ט		Usual Residence of Decedent								
	anylar how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 XNo
	8a-f	Directo	Maryland Anne Ar	undel		Gambr:	10f. Zip Code			og. Citizen of What	
	with t	Ö	10e. Street and Number	Desista			21054		1	USA	Country?
	na 23	Funeral	2607 Chapel Lake	12. Was Dec	cedent Ever in U	.S. 13.	Was Decedent of Hi	spanic Origin? (Specify Yes or No-	14. Race - Ar	nerican Indian,
0	r then		1 Never Married 2 Married	Armed F	orces? 2 X No		If Yes, specify Cubai	n, Mexican, Pue	rto Rican, etc.)	Black, W	nite, etc.
ğ	within 72 hours after death with the Maryland one. Than "patural", or items 23a or 28a-f show ha Medical Examinar must be notified at	i by	3 XWidowed 4 □ Divorced	If Yes, G Year or	ive Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
5-0	72 h	Completed	15. Decedent's (Specify only highest)	(Give	dent's Usual Occupa	uring most of w		16b. Kind of Busine	ss/Industry
121	within no. than	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use retired, nemaker			Home	
17 17	filed v Hygie ther t	ပိ	12 L11 17. Father's Name (First, Middle, La	st)		ПОІ	Hemaker	18. Mother's Na	ame (First, Middle, M		
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan dd Menial Hygiene. The Hygiene Hygiene marked other than "natural", or items 23a or 28a-f show martic event, the Modical Examination into the hydical Examination of the modifier at	To Be	Frank Hi	ırst				Elsi	le Louise	Davis	
ary			19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a	nd Number or F	Rural Route Number,	City or Town, State	, Zip Code)
	t and 2 Health a Iem 27 Is		Mary C. Pleffner	/ Daugh				d, Harwo	od, MD 20	776	
altimore,	of He of He if Item		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	☐Removal from	n State	emetery, cre	osition (Name of matory or other place			20c. Location - City	- 1
Ē	Pages tment of I tent: If Its jury or o		4 □ Donation 5 □ Other (Spe	city)	Ka		rematory	1		Edgewater	
Ba	permit. Pages Department of I Importent: If Its any Injury or or once.		21. Signature of Purpers Service Lie	ensee					-		neral Home , MD 21037
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	inplications that	caused the deat each line.	h. Do not en	ter the mode of dying	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
Ya.	Physician		Immediete Cause (Final disease or condition	a	Bra	in -	Tumor				Imont4
	/Medical Examiner		resulting in death)	Due to	o (or as a conseq	uence of):					
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Ć	exection and ial-tra	Exa	resulting in death) Last	C. Due to	o (or as a conseq	uence of):					
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9	ng ph	Med	IF FEMALE:								
Вох	seath certifica attending ph for use as th	lan/l	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 ☐ Feta	I death 3	Ectopic pregnancy			23d. Date of o	delivery Day Year
		Physician/Medical	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preq 9⊟Unk	gnant at time of d nown	leath 5L	Other (specify)				
0.0	The law requires that the ate has been signed by th page 2 should be detache		Part II. Other significant condition	s contributing to	death but not res	ulting in the u	inderlying cause give	n in Part I.	23e. Did tot	acco use contribute	to the cause of death?
rds	quires n sign	d by							1 □ Ye	s 2 10 3	Probably 4 Unknown
Division of Vital Records,	aw requir as been si 2 should	Completed							24a. Was a		autopsy findings available
m m	The la	mo:							autops perform	ned? death	o completion of cause of ? es 2 70
ita	ysiclan: The is certificate had director, page	Be	25. Was case referred to medical examiner?		-			26. Place of D	eath (Check only on	9)	
7	Attending Physician: r death. ector: After this certifica by the funeral director, I	ို	1 ☐ Yes 2 ☑ No	-	Inpatient 2			4 🗀 Nursing	Home 5 ☐ Reside		Daughter's Home
N C	ding P	0	27. Manner of Death 1 ☑Natural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time of Injury	Work	rat ? /es 2 ∐No	28d. Describe ho	w injury occurred	Tionic
isi	or Attendi after death. Director: A	lcat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be and Die	ce of Injury - At h	ome, farm, st	reet, factory, office	163 2 110	28f. Location (St.	reet and Number or	Rural Route Number,
<u>≥</u>	i Diffe	Certification:	4 ☐ Homicide determin	buil	ding, etc. (Specif	(y)	, , , , , , , , , , , , , , , , , , , ,		City or Town		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		caminer: On the					ce, and due to the ca curred at the time, da		
	within To the	Me	29b. Signature and title of certifier		1		29c. License			9d. Date signed (Mo	
			Ham 6	. Carent	h mn		73	31602		5/17/	6
			30. Name and address a person w				Print)	_		1	
			4201 Mitchell	Wille Ro	Bo Boistra de Sin	wie, M	120714	6	carge Can	anayh m	7
	Sta Registi		31. Date filed (Month, Day, Year) MAY 17	2006	Som /	B 4	north .		eorge Can	<i>V</i>	

		•	For State Registrer		State of	f Marylaı	nd / Dep <i>Ce</i>	artment rtificate				1ental F	lygier	201	16	174	88
	Dhysial		1. Decedent's Name	(First, Middle,	Last)							2. Date of Month		Day	Year	3. Time of D)eath
	Physici: /Medic		LENETTE					,				May	18,	2006		0235	М
	Examin	er	4a. Facility Name (If							Location of	of Death			4c. County			
		4-			Hospita				ast		04 1170			Tal	lbot		
в	Funeral Director		5. Social Security Nu 219-44-20	63	6. Sex 1 □ M 2 F	7. Age (In yrs	. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of (Month),	Day, Yea	1944	Cour	lece (State or itry) ISLANA	Foreign
	and		Usual Residence of I 10a. State	10b. County		10c. C	ity, Town or L	ocation				-			1	0d. Inside City	/ Limits
	Manyl f sho	ō	MD	TALBO	OT		EA	STON								1 🗌 Yes	2 X No
	death with the Maryland ime 23a or 28a-f show ir must be notified at	Director	10e. Street and Num	ber				10f. Zip	Code				10g.	Citizen of W	hat Cour	itry?	
	3a or	ā	28372 CAI	NVASBAC	CK LANE				216	01				U	SA		
	ms 2	Funeral	11. Marital Status			edent Ever in l	J.S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Sp	ecify Yes or Rican, etc.)	No-			an Indian,	
9	or items		1 Never Marrie	d 2 XMarrie	Armed Fo ad 1 Tes If Yes, Giv	2X No		1 Yes 2				riicari, etc.,			c, White,		
8	5 5 5	d by	3 Widowed 4	Divorced	Year or Da	ates:		10,000		Opcony.				Specify:	HW	ITE	
215-0036		Completed	(Specif	 Decedent's only highest 	s Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>Juring</i> mos	t of work	ing	16b.	. Kind of Bu	siness/In	dustry	
		d L	Elementary/Secon	dary (0-12)	College (1	-4or 5+)		EMAKE		,				OWN H	OME		
e11 nd 21	be filed within ital Hygiene. Id other then "	ပိ	17. Father's Name (F	First, Middle, L			11011	THE ROOM LE		18. Mothe	er's Name	ө (First, Mid					
Satchel Maryland	B a b y	To Be	LEONAR							ETTA	LIW &	LSON					
ary	AS DE E		19a. Informant's Nar	me/Relationsh	ip (Type, Print)		19b. Maili	ing Address	(Street a	nd Numbe	er o <i>r R</i> ur	al Route Nu	mber, Cit	y or Town, S	State, Zip	Code)	
	1 and 2 Health a am 27 is		LOU E. S	ATCHELI	L/HUSBAND		2837	2 CAN	VASB	ACK I	LANE,	, EAST	ON,	MD 21	601		
e j	of He of He fitan roth		20a. Method of Dispo		3 □Removal from		Place of Dispo cemetery, cre	osition (Nam matory or of	ne of ther place			Date	20c.	Location - (City or To	wn, State	
nette	Pages ment of ant: If it ury or o		4 Donation			OX	CFORD C	EMETE	RY	5	5/23/	/2006	OX	FORD,	MAR	YLAND	
Lenet Baltin	permit. Pages 1 Department of H Important: If its any injury or otl		21. Signature of Fun	eral Service L	icensee	E. CF	59 E	ELLOW 00 S.	Addres S, H HAR	ELFEN RISON	BEIN ST	N & NE EASTO	WNAM N, M	FUNE D 216	RAL 1	HOME PA	k.
	3/1		23a. Part 1. Enter the shock, or hear	e disease, or o	complications that conly one cause on e	aused the dea	ath. Do not en	ter the mode	e of dying	g, such as	cardiac	or respirator	y arrest,			Approximate Interval Betw	een
	Physician	3	Immediate Cause (F	inal	. Me	tas	toe t	ic 1	Bla	dde	2~	Cai	1	non	IC'	Onset and De	aath
	/Medical Examiner		resulting in death)			(or as a conse											
107	LAGITHITE	8	Sequentially list con	ditions,	b	(25.20.2.20.20.	augus of).										
	ed isit	lue	Sequentially list con it any, leading to im- cause. Enter Under Cause (Disease or in	mediate lying niury	Due to ((or as a conse	querice or);										
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ŏ	leath certifica attending ph	Z W	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out			75-4						23d. Date	of delive	ory	
Ď.	death e atte	icia	in the past 12 r			irth 2 □Fet ant at time of		□Ectopic pro □ Other (spe					_	Mon	th	Day Ye	9ar
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s,	res that the de signed by the a be detached to	by	Part II. Other signific	cant condition	ns contributing to de	eath but not re	sulting in the u	underlying ca	ause give	n in Part I						ne cause of de	
ord	w require been sig should b	ted										1	□ Yes	2 000	3 D Prob	ably 4 □Ur	iknown
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<u> </u>	The law cate has i	S										1 □ Ye	s 2		eath?	2 🗆 No	
Vit.	ysician: Th is certificate director, pag	Be	25. Was case referre examiner?	ed to medical	Hospital: No.				Othe	200		h (Check on					
o	Phys this ral dii	: To	1 Yes 8 27. Manner of Death		134		ER/Outpatie		A	4 🗆 NL	ırsıng Ho	me 5 R				v)	
Ö	ding h. After fune	tion	1 SHatural 2 Accident	5 Pending	, ,	of Injury th, Day Year)	Injury	м	8c. Injury Work	? ∕es 2 🔲	No			, ,			
isi	Atten r deal sctor: by the	fica	3 Suicide	6 Could n	ot be 28e. Place		home, farm, st	reet, factory	, office						r or Rura	I Route Numb	ΘΓ,
ă	ai or A s after if Direct	Certification:	4 Homicide		buildi	ng, etc. (Spec	erfy)					City or	Town, St	are)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C			Physician: To the exeminer: On the ba												
	within To th compl	Me	29b. Signature and t	itle of certifier	0	_		290	License	number			29d. l	Date signed	(Month,	Day, Year)	
			Do.	done	- Le At	Ja de	2	0	004	531	10		M	ay 1º	8 -	200 4	5
			30. Name and addre					, Print)						,	1		
	10-				HIELDS M.I			HINGT	ON S'	T., E	EASTO	ON, MD	216	01			
	Sta Registi	- 25	31. Date filed (Monti	MAY 1		legistrar's Sign	iature .	bod									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** May 18, 2006 Year Evelyn Thirkell 8:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Somerford Assisted Living Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 203, 17937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 21 F 98 Pennsylvania 374-18-3252 Vre Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ▼Yes 2 No Director Maryland Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 2100 B Whittier Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes Y No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coltege (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Hamilton Whigham Bertha 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna J. Barefoot/Niece 54 Hillside Drive Carlisle, PA 17013 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rest Haven Mem Gards. 5/22/2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death oronau Mey Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a consequence of) Examine use as the burial-transit and Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ tension 2 🖹 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 certificate 1□ Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Mannef of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atl within 24 hours after d To the Funeral Direct 4 Homicide 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Freder Haa 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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	1 = For State Registrar		y (an 10		artment of I <i>rtificate of</i>				Reg. No.	000	5	17491
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dical	KAY FRANCES 1 4a. Facility Name (If not institution)		nhar)		4b. City, Town,	or Location		hay	10	200 County of De	6	2304 1
niner			HOSPIT	AL	E. City, Town,	ASTO	,		40.0	TAL		7
-70:	5. Social Security Number 213–44–0955		7. Age (In yrs. la.		If Under 1 Year Months Days	If Under	24 Hrs. 8	Date of Birt (Month, Day	h v_Year)	9. 8	Birthplac	e (State or Foreig
1	Usual Residence of Decedent	A	02	115.			0	CT 19	1943	M	ARYL.	AND
1. 1	10a. State 10b. Count	•	10c. City,	Town or Lo							10d.	Inside City Limits
Director	MD TA	LBOT		EAST	ON 10f. Zip Code				10- 0'''			1 Yes 2 No
2	9174 HONEYSUC	CKLE RD			216	601			rog. Cilize	on of What		f.
Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	. 13.	Was Decedent of I		igin? (Speci	fy Yes or No-	14	I. Race - Ar Black, Wi	merican	
by Fi	1 ☐ Never Married 2 ☐ Ma 3 █️Widowed 4 ☐ Divorce		e		1 □ Yes 2 X No			,		pecify: W		
ted	15. Decede	nt's Education	103.		dent's Usual Occup					d of Busines		
Completed	Elementary/Secondary (0-12)	ost grade completed) College (1-	-4or 5+)	life. i	kind of work done DO NOT use retire	during mos ad)	it of working					
	17. Father's Name (First, Middle	Last)		Н(OMEMAKER	18 Mothe	ar's Name /	First, Middle,		HOME		
To Be	WILBUR STINCE						LLIE	TARBU		umame)		
	19a. Informant's Name/Relation				ng Address (Street	t and Number	er or Rural F	Route Numbe	r, City or T		a, Zip Co	de)
	CHRIS HADDAWA 20a. Method of Disposition	Y/SON	20h Bla		2 MARLAN	DR.,	46.744.66					
'	1 🗆 Burial 2 🗶 Cremation		cen	netery, cren	sition (Name of natory or other pla		Dat			tion - City		
	4 ☐ Donation 5 ☐ Other (3		CHES	4	CREMAT							
	Town i	2 mea			FELLOWS,	HELFE	NRETN	& NITH	NAM F	TINERA	T 17/	AMER TO A
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			1 - For State Registrar	State of	Maryland			of Health and of Death	Mental H	ygiene	1749
	Physici /Medi		Decedent's Name (First, Middle John	R.	W	hisner		Sr.	2. Date of D Month May	Death	3. Time of Death 6:50 am
1	Examir	ner	4a. Facility Name (If not institution 12617 Bowling	Street			Cum	or Location of Dea		Alleg	
	Funeral Director		5. Social Security Number 219-44-0928 Usual Residence of Decedent	6. Sex 7 1 □ X M 2 □ F	. Age (In yrs. Ia:	Yrs.	If Under 1 \ Months D	ear If Under 24 Ho ays Hours Mi	B. Date of B. Month, B. Mar S	9, 1943	Birthplace (State or Foreign Country) MD
	Maryland a-f ehow	tor	MD 10b. County	gany	10c. City,	Town or Lo Cum	cation berland				10d. Inside City Limits 1 □XYes 2 □ No
	th with the 23e or 28	al Direc	10e. Street and Number 12617 Bowling	Street			10f. Zip Co	21502			What Country?
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mential Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Examination and be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	ned 1 XYes 2	1961)	Vas Decedent f Yes, specify	of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or N into Rican, etc.)	lo- 14. Ra Bla Speci	се - Атеrican Indian, ick, White, etc. ^{fy:} white
Maryland 21215-0036	filed within 72 h Hygiene. sther than "natu	Completed	(Specify only highe Elementary/Secondary (0-12)	l's Education st grade completed) College (1-4	for 5+)	(Give	DO NOT use r	one during most of w	orking	16b. Kind of E	Business/Industry ailroad
yland	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Ms	To Be	17. Father's Name (First, Middle, Charles Dad							e, Maiden Sumai tansberry	v) Whisner
	Page ent c nt: If ry or		19a. Informant's Name/Relations Jannette Whis	hip (Type, Print) NET Wil	fe	19b. Mailin 126	9 Address (SI 17 Bow	reet and Number or F rling Street	Rural Route Numi Cum	ber, City or Town nberland	MD 21502
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Placent	ce of Dispos netery, crem Llawn M	sition (Name of natory or other emorial	Gardens	Date 6/1/2006		- City or Town, State MD
Ball	permit. I Departm Importar any inju		21. Signature of Funeral Service	DY. Ka	and	X	108	pelli ⊄ūneral Virginia Aven	ue: Cumbe	erland, MD	21502
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۵	signed d be de	by	Part II. Other significant condition	ons contributing to dea	th but not resulti	ing in the un	derlying caus	given in Part I.			tribule to the cause of death?
	The law ate has b page 2 sl	Completed	-						24a. Was	s an 24b.	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Zi.	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nationt 2 E	VOutpatien!	3□ DOA	Other	ath Check only	one) idence 6 □Oth	
	ding After fune		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of (Month,		Bb. Time of Injury	28c.	njury al Work? 1 Yes 2 No		how injury occur	
ā	ital or Atturs after de sal Directo	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 289. Place of	Injury - At home , elc. (Specify)	e, farm, stre	et, factory, off	ice	28f. Location (City or To	(Street and Numb wn, State)	per or Rural Route Number,
	Hosp 4 hou Fune ety fill	edicai	29a. Certifier (Check only one) 1 ★ Certifyin 2 ★ Medical	g Physician: To the be examiner: On the basi and manner	is of examination	edge, death n and/or inve	occurred at the	e time, date and plac ny opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
)	To the within 2 To the complet	M	29b. Signature and title of certified	m 6.6	Grant	MI	4	ense number		_	d (Month, Day, Year) 0, 2006
	6		30. Name and address of person Thomas E. Chapp		. 7.00000			Cumberland	, MD 21	502	
华	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 2006	e 20 De-	isIrar's Signatur	_					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 22, 2006 Year **Physician** 4:30 P. M Margaret Louise Williams /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lonaconing Egle Nursing Home Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) Days 1 M 2 K F Yrs. 214-32-3269 Director 94 December 31, 1911 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iteme 23a or 28e-1 show any Injury or other traumatic event, Ina Medical Ever Line Invest he rutilised at once. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 XYes 2 No Director Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Jackson Street 21539 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Specify: Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Coleman Mary Catherine Hixenbaugh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Schlereth - Daughter 11 Allegany Street, Lonaconing, Maryland, 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date May 26, 1

Burial 2 □ Cremation 3 □ Removal from State Frostburg Memorial Park Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Enzie Funeral Home P.A., 8 East Main St., 21. Signature of Funeral Service Licensee Lonaconing, Md. 21539 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final accident **Physician** erebio Vusculer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 Yes 2□ No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of confiler Douglas Ave, Lanacaning, 121539 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nomas Devlin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year May 21, John Alovsius Wathen 2006 12:21 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 1280 Avery Road Calvert Huntingtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 30, **Funeral** Birthplace (State or Foreign Country) Months Days 1**™**M 2□F Hours Min 218-34-5870 70 Director Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Director 1 ☐ Yes 🌠 No Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 1280 Avery Road 20639 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after ☐Yes 2XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'netural', or 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Pages 1 and 2 should be filed and of Health and Mental Hygient: If Item 27 is marked other Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Briscoe Wathen Addy M. Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health ar Important: If Item 27 is any injury or other trauonce. Catherine Pauline Wathen / Daughter 1280 Avery Road Huntingtown MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens | May 25, 2006 Leonardtown, MD 21. Signatur of Funeral Service Licensee Mattingley Gardiner Funeral Home, P.A. Thechael 23a. Part 1. Enter the disease or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER METASTATIC LUNG YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (us as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 TUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director: After this certificate has I
in by the funeral director, page 2 s autopsy performed? 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The destination is the destion by knowledge, death occurred at the limit, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40370 122106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Peter Wisniewski 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Short & ford Registrar

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ORIGINAL

		1- For State of Maryland /	Dep		of He	ealth an		ental Hyg	iene g. No.20	06	1749						
Physicia /Medica Examine	al	Decedent's Name (First, Middle, Last) Larry E. Ware 4a. Facility Name (If not institution, give street and number)		4b City To	own or l	ocation of D		Date of Dea Month May 13	Day	Year of Death	3. Time of Death 12:05 A						
/ Funeral Director		Prince Georges Hospital 5. Social Security Number 497-30-7305 6. Sex 1 M 2 D F 75	oirthday) Yrs.	Che	ever	1y If Under 24 I		Date of Birth (Month, Day Oct.6,	Prin	ce Ge	eorges place (State or Foreigntry) MO						
the Maryland 28a-f show	ector	Usual Residence of Decedent									l0d. Inside City Limit						
s 1 and 2 should be filled within 72 hours after death with the Maryland fleath and Mental Hygiene. Item 27 le marked other then "naturel; or Iteme 23a or 28a-f show other traumatic event, the Medical Evantiner must be notified at	by Funeral Director	12615 Kauanaugh Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 155-16			715 nt of His y Cuban	panic Origin? , Mexican, Pi Specify:	? (Speci uerto Ri	fy Yes or No- can, etc.)	Blac		can Indian, etc.						
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s 1 and 2 should be 1 if the all hand Mental item 27 is marked to other traumatic even	0	Chris S. Ware/ Son	1503	Farlo	w A	d Number or	Rural F roft	on, MD	City or Town,	ŀ							
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To t To t com		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	(Type.		icense n		2_	16	d. Date signed	(Month, L	Day, Year) D 6						
State Registrar		31. Date filed (Month, Day, Year) 32. Resistrar's Signature MAY 1 7 2006	w.	Color	eens	ibung 1	स्व	Hyal	15 1/e	Neis	12081						

Dorena Washingt	Baltimore, Maryland 2121	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hydiana
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		•	For State Registrer	State of M	aryland		irtment of Ho tificate of L			giene) (Reg. No.	006	17495
N. S.	Physici /Medic		Decedent's Name (First, Middle, Last) Dorena France	Washing	gton				2. Date of De Month May	Day	2006	3. Time of Death 4:00 AM
	Examin	_	4a. Facility Name (If not institution, give s Genesis Health			ines	4b. City, Town, or Eas		ath	4c. Coui	nty of Death Talbo	·+
	Funeral Director		5. Social Security Number 6. Sex	7. Ag	je (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	ff Under 24 H	n. (Month, Da	y, Year)	9. Birthp Coun	lace (State or Foreign try)
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	th the Man or 28e-f sh	Director	Maryland Dorchest 10e. Street and Number	er	I	Hurloc	k 10f. Zip Code			10g. Citizen	of What Cour	1 ☐ Yes 2 X No
036	y within 72 hours after deeth with the Maryland liene. r then "natural", or Items 23a or 28e-f show the Medical Exantrar must be motified at	by Funeral	4726 Skeet C1u 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces?	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give		21643 3. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri		(Specify Yes or No arto Rican, etc.)			
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Mary	and and sm		19a. Informant's Name/Relationship (Ty				g Address (Street a					,
Baltimore, I	0 0		Doretha Colling 20a. Method of Disposition 1 Natural 2 Cremation 3 R 4 Donation 5 Other (Specify)	s / Daugh	20b. Pl	ace of Dispo metery, cren	sition (Name of natory or other place)	Date	Hurloc 20c. Locatio	n - City or To	
Baltir	permit. Pag Department Important: any injury c		21. Signature of Funeral Service License		> ret	22	cg Cemete Name and Addres Bennie Sm 516 S.Mai	s of Facility ith Fun	eral Home	2		
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Δ,	quires that in signed by uid be deta	þ	Part II. Other significant conditions con	ntributing to death t	out not resu	Iting in the u	nderlying cause give	n in Part I.		obacco use co Yes 2 No		ably 4 Unknown
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Ď	To the within To the Comple	Me	29b. Signature and title of certifier	Pender	. MD		29c. License	number 72.593	33	29d. Date sig	ned (Month,	
			30. Name and address of person who comic that Roule	My MD	61	OD	Print) UTCHMAN	s La	NE E	ASTO	N MD	21601
	Sta Regist		31. Date filed. (Month, Day, Year) MAY 1 5 2005	. Regist	rar's Signat	lure	A.				,	

06-03513

Please Type or Print in Black Indelible Ink Maryland / Department of Health and Mental Hy

DII Allueisuli		1- For State Critificate of Dea	nth	Reg No. 2007 1710					
Physici edical Exam		Leon Anderson	2 Date o Month May 2						
			, Town, or Location of Death rdeen	4c. County of Death Harford					
Funeral Director		217-62-4468 1 M 2 F 51 Yrs Mon	ths Days Hours Min	of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) WASh.DS					
any any any	<u>ا</u>	Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Belcamp		10d. Inside City Limits 1 Yes 2 No					
ith the Maryland 23a or 28a-f shown notified at once.	Director	10e Street and Number 10f. Z	1p Code 2 1017	10g. Citizen of What Country?					
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MD 21215-0036 2 should be fifted within 72 hours after death with the Maryland b and Mental Hygies T is marked other than "natural", or items 23a or 28a-f sh imatic event, the Medical Examiner must be notified at once	þ	3 Widowed 4 Divorced If Yes or Pales: 15 December 5 Education (Specific or Pales): 16 December 6 Heavier (Specific or Pales): 17 December 7 Divorced or Pales: 18 December 7 Divorced or Pales: 19 December 7 Divorced or Pales: 10 Divorced or Pales: 10 Divorced or Pales: 11 Yes or Pales: 12 December 7 Divorced or Pales: 13 December 7 Divorced or Pales: 14 Divorced or Pales: 15 December 7 Divorced or Pales: 16 December 7 Divorced or Pales: 17 Divorced or Pales: 18 December 7 Divorced or Pales: 18 December 7 Divorced or Pales: 19 Divorced or Pales: 19 Divorced or Pales: 10 Div	No specify al Occupation (Give kind of work done orking life. DO NOT use retired)	16b Kind of Business/Industry Ine Swift CO.					
215-0036 be filed within 72 nal Hygiene -ked other than *	Completed	11 +h 17. Father's Name (First, Middle, Last)	18 Mother's Name (First, Mic	ddle, Maiden Surname)					
21215 nould be file is marked title event. I	To Be	LONNIC ANDELSON ST. 19a. Informant's Name/Relationship (Type, Print) Ex-wife 19b. Mailing Address	ss (Street and Number or Rural Route	lizabeth Jones e Number, City or Town, State Zip Code)					
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	l,			6 Baltimore an Harris Funeral Home					
Physician /Medical Examiner		23 Part I. Ericr til disease, or complications that caused the death. Do not enter the mode failure. Ist only one cause on each line Immediate Cause (Final disease or condition resulting in death) The part I. Ericr til disease, or complications that caused the death. Do not enter the mode failure. The part I is a support of the part of the part of	e of dying, such as cardiac or respirato	Between Onset and					
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Vital Reo	Be	25. Was case referred to medical examiner? Hospital: 1 Inserting to 2 FR/Outpotcost 2	26.Place of Death (Check only one) DDA Other4 Nursing Home	5 Residence 6 ✓ Other: Scene					
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce								
To with	Med	and manner stated 29b Signature and title of certifier 25	9c License number	29d Date signed (Month, Day, Year)					
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	May 25, 2006					
		20 50 110	Penn Street, Baltimpre, MD 2	1201					
S Regis	itate strar	11 13 13 E 200C KA: OF AT	,						

			For Stata Registrar	State of	Maryland		artment of H		nd Mer		giene Reg. No. 2	006	17497	
	Physici /Medio Examin	al	Decedent's Name (First, Middle,	rie Al	ene	2	4b. City, Town, o	or Location of		Date of Dea Month	Day 29	Year Oldonty of Death	3. Time of Death	
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Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Supplies Li)	ecify)	ate cen	netery, cren dens O	sition (Name of natory or other place of Faith Co. Name and Addre	emeter			Baltir	n-City or To		
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Divis	To the Hospital or Attendi within 24 hours after death To the Funeral Director: K completely filled in by the fi	al Certification;	3 Suicide 4 Homicide 4 Homicide 29a. Certifier 1 Certifying	ed 286. Place of	, etc. (Specity)		eet, factory, office	ne, date and		City or Town	n, State)		Route Number,	
•	To the Ho within 24 t To the Fu completely	Medical	(Check only 2 Medical E.	xaminer: On the basi and manne	s of examination stated.	on and/or inv	estigation, in my o	pinion, death	occurred a	t the time, d	ate and place	e, and due to	the cause(s)	
	Ú.	18	30. Name and address pe w GCCD 31. Date filed (Month, Day, Year)	ho completed cause	PIナア of death (Item 2	51C/A 23a) (Type, 1 125	Print) 2 1	4920	NA11 3A27	MOR	0, 1	D		
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	5 2006 ^{32. R}	strar's Signatu	re se	goarde)	,						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 0 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** 6:30 PM M 2006 May 31, Amoroso Μ. Ann /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 13814 Flint Rock Road 8. Date of Birth (Month, Day, Year, May 23, 19 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months 1 □ M 2 🖔 F Yrs. 1919 West 87 Director 374-12-5494 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State rithen "naturel", or iteme 23a or 28a-f show the Medical Examinar count for notified at 1 Tes 2 No Rockville Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20853 13814 Flint Rock Road r death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 🏖 No Specity: Baltimore, Maryland 21215-0036 37 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker liled other 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Marasco Mary Frank Marra ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13814 Flint Rock Road, Rockville, Maryland 20853 Health : Diane Brasile/Daughter E E 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 5, 0 = 0 XXBurial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or once. 5 Oyher (Specify) 2006 Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 21. Signature of Junera Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850 M00877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Cell Lung Cancer 10 Months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2X No 1 ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death |Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 3 DOA Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injun 5 Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide filled in by 4 Homicide Hospital 1 🖾 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54378 June 1, 2006 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 2730 University Blvd., #400, Wheaton, MD 20902-1972 Aylesworth, M.D., Cheryl A. 31. Date filed (Month, Day, Ye 32. Redistrar's Signature State 200\$ Registrar

			1 - For State Registrar	State of Marylan		artment of F		Mental Hy	/giene	06 17499	
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last, Or P Q 4a. Facility Name (If not institution, give	Bak	er	4b. City. Jown. o	r Location of De	2. Date of Di Month Marth	Day	Year 3. Time of Death	
* 120	Funeral Director	ier	5. Social Security Number 6. Sec 234–48–3141	Ksley Hu		Balty If Under 1 Year Months Days	If Under 24 Hr Hours Min	s. 8. Date of Bi	nth ay, Year)		
	filed within 72 hours after death with the Maryland Hygiene. thar then "natural", or items 23e or 28e-1 ehow ent, the Madical Exeminating the neitlifed at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland n/a	10c. Cit	y, Town or Lo Balti	more				10d. Inside City Limits 1 X Yes 2 □ No	
	leath with the 23a or 2	Funeral Director	10e. Street and Number 2106 Parksley Aver	S 13	10f. Zip Code 21230	ispanic Origin?	Specify Ves or N	United	Og. Citizen of What Country? United States 14. Race - American Indian,		
0036	nours after d ural', or Iten	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or Note of Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2X No Specify:			Blac Specify	k, White, etc.	
21215-0036	od within 72 h giene. ar then "nati	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of Bu	n Home	
Maryland	should be file ad Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Wendell McBride 19a. Informant's Name/Relationship (Ty	na Print)	10h Mailir	18. Mother's Name (First,) Ori McBride ng Address (Street and Number or Rural Route			iddle, Maiden Sumame)		
	and 2 s lealth an m 27 le har trau		Roger Lee McBride	/ Son	2106	Parksley	Avenue,	Baltimo	re, Mary	land 21230	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked othar then "natural", or Items 23s or 28s-f ehow amy injury or other traumatic event, the Macical Examinat must be notified at angle.		20a. Method of Disposition ☐ Bugal 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Cignatur of Funeral Service License	Ba	yview	sition (Name of natory or other place Crematory 2. Name and Addres	7 06,	Date /03/2006 ubbard F	Baltimo	city or Town, State re, Maryland ome, Inc.	
8	89 E 8 8		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	4	107 Wilke	ens Aven	ue, Balt	imore, M	aryland 21229	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Oue to (or as a consequence	100	of	Col	on		Interval Between Onset and Death 6 month	
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
O. Box 6	death certifi e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy			23d. Date Mon	o of delivery th Day Year	
rds, P.	rires the signed d be de	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause give	n in Part I.			bute to the cause of death?	
Vital Records,		e Completed	25. Was case referred to medical						osy pr rmed? de 2 No 1	prior to completion of cause of death?	
<u></u>	ding Phys	ToB	examiner?	26. Place of Death (Check only ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5/2 Re 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M Injury 1 Yes 2 No				Home 5/2 Resid			
Division	를 를 들는	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	")			City or Tov	vn, State)	r or Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral completely filled	ledicai	29a. Certifier (Check only one) (Check only one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)	
,	vith To corr	Σ	29b. Signature and title of certifier Aroa Jun	N Maee	$\gamma \gamma$	29c. License	1550	3	29d. Date signed	(Month, Day, Year) B) 2036	
	Ji.		30. Name and address of person who co	NAECM	501	Dophi	250	B.Ho	my 2	MAD	
	Sta Registr	-	31. Date filed (Month, Day, Year) JUN 0 5 201	32. Fe gistrar's Signat	O. A.	ente					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#2,per/ID, 76, per/erbal (856,6/5/06 TT)

State of Maryland, Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -May 27, 2006 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician oroth 3:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pem brooke Avenue Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Months Hours 213-09-0762 Director Washington Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehov other traumatic event, the Medical Examinar must be notified a Baltimore 1 Yes 2 □ No Funeral Director MI 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 21206 Pembrooke 5120 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Black Completed by Specify: 3 Widowed 4 □ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "nt eny Injury or other traumatic event, tra Medit once. Elementary/Secondary (0-12) College (1-4or 5+) tom 9th Grade tome maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmwel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Banks. Walk Valerie Vaughter 15 Carriage Balto. mD 2/234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Wood lawn D Baltimore Wood 4 ☐ Donation 5 ☐ Other (Specify) (en 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BeTT 5 Funeral 5+ arbline 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician Leukemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed? res 2 No 1 Yes Division of Vital To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2300 Dulaney Valley RD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood laria 31. Date filed (Month, Day, War) State JUN 0 5 2006 Registrar